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ABSTRACT

This document contains witness testimonies and prepared statements from the Congressional hearing called to examine issues involved in maintaining and strengthening Medicare Health Maintenance Orgranizations (HMO). Opening statements are included from Representatives Edward Roybal, Matthew Rinaldo, Mario Biaggi, Don Bonker, Robert Borski, Louise Slaughter, Harris Fawell, Ralph Regula, Jim Saxton, Jim Lightfoot, Constance Morella, and E. Clay Shaw, Jr. Congressman Dan Mica discusses problems with one HMO program and mentions legislation he is introducing to provide for study of the structure of HMOs in the future. William Roper, administrator of the Health Care Financing Administration discusses Medicare's experience with HMOs and with competitive medical plans. Other witnesses providing testimony and/or prepared statements include: (1) William Gunter, insurance commissioner, State of Florida; (2) Eva Skinner, American Association of Retired Persons, representing the Leadership Council of Aging Organizations; (3) Donald Reilly, Leadership Council of Aging Organizations; (4) Robert Crane, vice president of Kaiser Foundation Health Plan in Oakland, California; and (5) Kathryn Langwell, senior economist and project director, Medicare Competition Demonstration Evaluation, Mathematic Policy Research, Incorporated. Additional material submitted for the record is appended. (NB)

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ED290077

MAINTAINING MEDICARE HMO'S: PROBLEMS, PROTECTIONS AND PROSPECTS

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

JUNE 11, 1987

Comm. Pub. No. 100-627

Printed for the use of the Committee on Aging

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MAINTAINING MEDICARE HMO'S: PROBLEMS, PROTECTIONS AND PROSPECTS

THURSDAY, JUNE 11, 1987

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 11 a.m., in room 345, Cannon House Office Building, Hon. Edward R. Roybal (chairman of the committee) presiding.

Members present: Representatives Roybal, Pepper, Biaggi, Bonker, Mica, Erdreich, McClure, Kennedy, Rinaldo, Hammerschmidt, Regula, Snowe, Tauke, Saxton, Bentley, Fawell and Morella.

Staff present: Fernando Torres-Gil, staff director; Judith Lee, deputy staff director; Gary Christopherson, professional staff member; Nancy Smith, professional staff member; Eddie Rivas, professional staff member; Austin Hogan, communications director; Carolyn Griffith, staff assistant; Diana Jones, staff assistant; Valerie Batza, staff assistant; Tom Puglisi, Congressional fellow; Robert Villa, Congressional fellow; Joseph Fredericks, deputy minority staff director; and Leslie Tucker, minority research assistant.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

The CHAIRMAN. Ladies and gentlemen, today the Committee on Aging is holding a very important hearing, to examine our experiences with medicare HMOs and to explore strategies for strengthening this critical medicare program.

Medicare HMOs have the potential to be either the best or the worst of health care worlds. Our responsibility to our parents and grandparents and to ourselves is to ensure that it is the best of worlds.

Given the recent, publicized problems with International Medical Centers, now is the time to move aggressively to restore beneficiary and Congressional confidence in medicare HMOs. Our review of the history of the medicare HMO program clearly shows that future Federal oversight must be stronger than it has been in the past, but without being overly burdensome.

Beyond these immediate concerns, much work remains to be done before medicare HMOs fulfill their promise. Most HMOs have yet to add long term care as a covered benefit or as an optional added benefit. Most HMOs, over 60 percent, have yet to join the medicare HMO program. HMOs serve less than 10 percent of the medicare population. Medicare HMOs have yet to serve major por-

tions of the rural population. As a result, many beneficiaries do not have the chance to use the medicare HMOs, let alone have choices of HMOs.

In the end, the ultimate test for the medicare HMO program is what we say to our own families. The ultimate test is whether or not we have the confidence to strongly recommend any participating and qualified medicare HMO to our own parents and to our own grandparents.

Ladies and gentlemen, at this time I would like to take the opportunity on behalf of the committee, to express my deep appreciation to one of the committee members who has been most instrumental in seeing to it that this committee makes careful examination of those things that are going on with regard to HMOs. I must give special thanks to Representative Dan Mica, who had the foresight and the resolve to tackle this issue long before the administration or anyone else was willing to acknowledge that there were significant problems, let alone try to solve them.

Representative Mica, with the assistance of Representative Matthew Rinaldo, who sits here to my left, and with Rick Boucher, conducted the full committee hearings on HMOs, not last year, but way back in 1984. I remember when permission was asked to hold those hearings. I, as chairman of the committee, knew very little about the issue at that time. But we were interested in finding out more. And these three men, under the leadership of Representative Mica, conducted those hearings and brought back an astonishing report to this committee. I would like to express my special appreciation also to my esteemed colleague and former Chairman of the Aging Committee, Claude Pepper, who has been a leader for years in trying to make HMOs available to the millions of medicare beneficiaries.

I bring all this out, ladies and gentlemen, because I want to point out that we in the committee have men and women that really believe that what they have to offer does make a difference. When these three men went out and had their first two hearings, they started to make a difference. The difference of course was that we as a committee started to realize that there was a problem not only in a particular State, but that same problem could be duplicated in HMOs throughout the country.

Yes, we're interested in looking at this problem. That is the reason for this hearing today, and we as the full committee wish to continue not only looking into the problem itself, but trying to find means and ways of solving that problem. We have, I understand, a quorum call. I would like to first of all call on Mr. Rinaldo, the Ranking Minority Member, for his opening statement.

STATEMENT OF REPRESENTATIVE MATTHEW J. RINALDO

Mr. RINALDO. Thank you very much, Mr. Chairman. I want to thank you for your kind words and commend you for holding this hearing of the Aging Committee, to address a topic of vital importance to senior citizens. The topic of medicare HMOs has been an important one on the agenda of this committee as we strive for a more cost effective means of bringing quality health care to medicare beneficiaries.

With the passage of TEFRA in 1982, Congress enacted risk-based contracts for medicare. Since that time, the number of people nationwide served by medicare HMOs has grown from approximately 100,000 to 867,000 enrollees. In my own home State of New Jersey, in 1984 there were approximately 2,000 medicare beneficiaries enrolled in HMOs. Today there are five TEFRA contracts with a total enrollment of over 14,500 people. In fact, one of these HMOs, with an enrollment of approximately 600, is located in Millburn, New Jersey, which I represent. Another HMO in Morristown, New Jersey has over 10,000 enrollees.

HMOs are one method of bringing down and slowing health care costs while retaining and improving quality health care. By increasing efficiency through the incentives inherent in HMOs, we help the elderly, by recycling savings to expand the level and breadth of coverage while eliminating the need for copayments and deductibles.

In the past there have been problems with HMOs, as my good friend and colleague Congressman Mica, who has worked so hard on this problem, knows very well. At a hearing of this committee just last year, many problems such as enrollment practices and grievance procedures were addressed. However, I think that these problems must be addressed in the context of what we hope will be steady improvement.

Our experience with HMOs has been one of learning and adapting. The responsibility falls on Congress and HCFA to improve Federal oversight to assure the quality care and to restore the beneficiary confidence.

In closing, Mr. Chairman, I again want to commend you for convening this hearing on medicare and HMOs and yield back the balance of my time.

The CHAIRMAN. Thank you, Mr. Rinaldo. May I announce that there is a quorum call on the floor followed by a vote. The committee is in recess.

Mr. SAXTON. May I ask permission at this point to have my opening statement placed in the record?

The CHAIRMAN. Without objection, it will be ordered. Anyone else who wishes to follow suit can do the same thing.

Mr. FAWELL. Mr. Chairman, I would like my opening statement placed in the record also.

The CHAIRMAN. Mr. Fawell. All right. All those who wish to submit their opening statements at this time may do so and without objection, they are approved and will appear in the record at this point. The Committee is now in recess for 10 minutes and will return and resume our sitting.

[Recess.]

The CHAIRMAN. The members have agreed, to submit their opening statements for the record, and they will appear in the record at this point. And the Chair now recognizes the man who has done a yeoman's job in working on this problem in the State of Florida.

Mr. Mica, the committee would like to welcome you and ask you to proceed in the manner that you may desire.

[The prepared statements of the Members follow:]

PREPARED STATEMENT OF REPRESENTATIVE MARIO BIAGGI

MR. CHAIRMAN, I COMMEND YOU FOR HOLDING THIS IMPORTANT HEARING TODAY. THE SELECT COMMITTEE ON AGING'S COMMITMENT TO A QUALITY MEDICARE HEALTH MAINTENANCE ORGANIZATION PROGRAM IS LONG STANDING. IN ADDITION TO THE TWO FULL COMMITTEE FIELD HEARINGS HELD IN FLORIDA, THE SUBCOMMITTEE ON HUMAN SERVICES CONDUCTED A HEARING ENTITLED " HEALTH MAINTENANCE ORGANIZATIONS: THE NEW YORK PERSPECTIVE " IN FEBRUARY OF 1986. WE ARE, HOWEVER, STILL LEARNING A GREAT DEAL ABOUT HMO'S AND THEIR ABILITY TO SERVE THE ELDERLY AND THIS HEARING IS QUITE TIMELY CONSIDERING THE EVENTS WHICH HAVE OCCURRED SINCE OUR OTHER HEARINGS.

I ALSO COMMEND MR. MICA FOR HIS STEADFAST COMMITMENT FOR IMPROVING THE QUALITY OF HMO CARE FOR OLDER AMERICANS.

MR. CHAIRMAN, I FIRMLY BELIEVE THAT HMO'S CAN PROVIDE QUALITY CARE AT A LOWER COST FOR MANY MEDICARE BENEFICIARIES. BUT IT IS OBVIOUS TO ME THAT CONGRESS AND THOSE OF US ON THE AGING COMMITTEE HAVE AN IMPORTANT ROLE TO PLAY IN PROVIDING THE NECESSARY OVERSIGHT AND GUIDANCE TO ENSURE QUALITY CARE. OLDER ADULTS MUST BE PROTECTED FROM DECEPTIVE MARKETING PRACTICES, UNFAIR ENROLLMENT STRATEGIES, INADEQUATE QUALITY ASSURANCE AND GRIEVANCE PROCEDURES, AND THE DENIAL OF ESSENTIAL SERVICES. OUR REVIEW AND ACTIONS MUST ALSO CONSIDER WHAT SAFEGUARDS ARE APPROPRIATE TO GUARANTEE THE FINANCIAL STABILITY OF MEDICARE HMO'S.

I HOPE TODAY'S TESTIMONY AND RESPONSES TO THE COMMITTEE'S QUESTIONS WILL ASSIST US IN DEVELOPING AN UP TO DATE UNDERSTANDING OF THE ISSUES, AND SOLUTIONS TO THE PROBLEMS THAT WE HAVE UNCOVERED. FURTHERMORE, WE MUST PLAN FOR THE FUTURE AND HOW WE CAN MAKE THE MEDICARE HMO A SAFE CHOICE FOR MORE OLDER ADULTS.

MR. CHAIRMAN, I WOULD LIKE TO BRIEFLY COMMENT ON SOME OF THE ISSUES THAT WERE RAISED AT THE SUBCOMMITTEE'S HEARING IN NEW YORK THAT ARE STILL VALID TODAY. NEW YORK HAS IN MANY RESPECTS

MIRRORED THE NATION WITH RESPECT TO HMO GROWTH OVER THE PAST SIX YEARS. YET, AS A RESULT OF NEW REGULATIONS ISSUED IN THE STATE, WE STAND TO LEAP AHEAD OF OTHER STATES IN TERMS OF HMO EXPANSION, ESPECIALLY IN THE "FOR PROFIT" SECTOR.

THESE REGULATIONS HAVE PROVIDED SPECIAL INCENTIVES FOR THE "FOR PROFITS" TO ENTER THE NEW YORK MARKET. WE HAVE SEEN A SIGNIFICANT INCREASE IN HMO APPLICATIONS AS A RESULT. IT IS MY CONVICTION, HOWEVER, THAT APPROVAL OF HMO'S BY EITHER STATE OR FEDERAL GOVERNMENT MUST BE ACCOMPANIED BY A RESPONSIBILITY TO ADEQUATELY MONITOR THESE HMO'S.

TODAY IN NEW YORK STATE, MORE THAN $50 MILLION DOLLARS IN MEDICARE FUNDS ARE SPENT PROVIDING HMO SERVICES TO ELDERLY BENEFICIARIES. THIS NUMBER WILL INCREASE AS WE WITNESS THE RAPID GROWTH IN OUR ELDER POPULATION, AND THE REST OF THE NATION WILL EXPERIENCE SIMILAR TRENDS. AS I HAVE SAID IN THE PAST, WE NEED TO GUARANTEE THAT THE GROWTH IN HMO'S DOES NOT BECOME JUST A BOON IN THE BUSINESS WHILE A BOONDOGGLE TO THE TAXPAYERS.

WE IN CONGRESS SHOULD NOT UNDERESTIMATE THE IMPORTANCE OF THE FEDERAL ROLE IN REGULATING HMO'S. CURRENTLY, THE EXTENT OF REGULATORY OVERSIGHT OF HMO'S VARIES CONSIDERABLY FROM STATE TO STATE. WE ARE LEARNING WHAT COMPETITION CAN MEAN TO THE HMO INDUSTRY, BUT COMPETITION IN HEALTH CARE HAS NOT ALWAYS PROTECTED THE BEST INTERESTS OF THE CONSUMER. SO WE MUST BE CAUTIOUS AND DETERMINED TO PROTECT OLDER CONSUMERS OF HEALTH CARE.

I RECEIVED TESTIMONY IN NEW YORK WHICH STATED THAT HMO'S THAT HAVE BEEN COMMITTED TO COMPREHENSIVE BENEFITS AND COMMUNITY RATING ARE NOW ENGAGING IN REGRESSIVE POLICIES, INCLUDING BENEFITS SLASHING AND SELECTIVE EXPERIENCE RATING IN ORDER TO COMPETE.

"SKIMMING" OR SEEKING ONLY THE HEALTHIEST POPULATIONS IS ALSO A THREAT TO THE ELDERLY'S BEST INTERESTS. THEREFORE, NEW YORK REGULATIONS NOW REQUIRE HMO'S TO SEEK OUT AND ENROLL A DIVERSE POPULATION. WE NEED TO BALANCE THE MARKET FORCES, WITH STATE AND FEDERAL REGULATIONS.

IN CONCLUSION, I BELIEVE THOSE THAT OPERATE HMOs CAN AND DO IN SOME CASES MAKE SUBSTANTIAL PROFITS, AND THAT IS ACCEPTABLE. AT THE SAME TIME, AN HMO CAN LOWER COSTS TO BOTH THE PARTICIPANT AND THE GOVERNMENT WHEN COMPARED TO HOSPITAL BASED AND INSTITUTIONAL CARE. BOTH OF THESE OUTCOMES CAN BE ACCOMODATED, BUT IT WILL TAKE HARD WORK, EFFICIENCY OF OPERATION, COMMITMENT TO QUALITY CARE AND FULL ACCOUNTABILITY.

I THANK THE DISTINGUISHED CHAIRMAN, MR. ROYBAL, FOR CALLING FOR THIS HEARING, AND I THANK THE WITNESSES FOR THEIR EXCELLENT TESTIMONY AND PARTICIPATION HERE TODAY.

PREPARED STATEMENT OF REPRESENTATIVE DON BONKER

MR. CHAIRMAN, I WOULD LIKE TO CONGRATULATE YOU FOR HOLDING THIS HEARING TO EXAMINE OUR EXPERIENCES TO DATE WITH THE MEDICARE HEALTH MAINTENANCE ORGANIZATION (HMO) PROGRAM.

ORIGINALLY INTENDED AS AN ALTERNATIVE TO FEE FOR SERVICE MEDICARE, HMOS HOLD THE PROMISE OF CONTROLLING SPIRALLING HEALTH CARE COSTS. A RADICAL DEPARTURE FROM TRADITION, HMOS HAVE BEEN AGGRESSIVELY MARKETED BY THE REAGAN ADMINISTRATION.

THE MEDICARE HMO PROGRAM SEEKS TO ACHIEVE TWO IMPORTANT GOALS: FIRST, THE DELIVERY OF HIGH QUALITY MEDICAL CARE FOR THE ELDERLY IN AN ECONOMICALLY EFFICIENT MANNER; AND SECOND, EQUAL ACCESS TO THIS ALTERNATIVE FOR ALL MEDICARE BENEFICIARIES.

THE HMO CAN PROVIDE A COMPREHENSIVE RANGE OF SERVICES IN EXCHANGE FOR A FIXED MONTHLY PAYMENT FROM MEDICARE AND IN SOME CASES AN ADDITIONAL MONTHLY PREMIUM FROM THE BENEFICIARY. IN MANY CASES, ADDITIONAL SERVICES SUCH AS EYE CARE AND PRESCRIPTION DRUGS, ARE INCLUDED IN THE BENEFIT PACKAGE.

WE ARE ALL VERY AWARE OF THE ELDERLY'S SERIOUS CONCERN OVER HIGH OUT OF POCKET MEDICAL EXPENSES. MANY ARE CHOOSING HMO PARTICIPATION, IN AN ATTEMPT TO PROTECT THEMSELVES FROM THE CATASTROPHIC EXPENSE OF CHRONIC ILL HEALTH. IN MY HOME STATE OF

WASHINGTON, THERE ARE THREE MEDICARE HMO CONTRACTS IN EFFECT.

AS MEDICARE HMO ENROLLMENT APPROACHES ONE MILLION, HOWEVER, SERIOUS DEFICIENCIES IN QUALITY OF CARE AND ADVERSE SELECTION HAVE SURFACED WITH SOME HMO CONTRACTS. THE RECENT FAILURE OF THE INTERNATIONAL MEDICAL CENTER IN FLORIDA, THE NATION'S LARGEST MEDICARE HMO WITH 135,000 MEMBERS, HAS SHAKEN THE CONFIDENCE OF MANY OLDER AMERICANS IN THE MEDICARE HMO APPROACH. THESE PROBLEMS MUST BE ADDRESSED BEFORE WE ALLOW ADDITIONAL MILLIONS OF SENIOR CITIZENS TO BE PUT AT POTENTIAL RISK.

CERTAINLY I ENDORSE THE GOALS OF THE MEDICARE HMO PROGRAM. IT IS WELL ESTABLISHED THAT QUALITY CARE CAN BE PROVIDED IN THE HMO SETTING IN A HIGHLY EFFICIENT MANNER. UNFORTUNATELY, OUR EXPERIENCES WITH SOME MEDICARE HMOS THUS FAR HAVE BEEN HIGHLY PROBLEMATIC. I LOOK FORWARD TO HEARING THE TESTIMONY OF OUR WITNESSES TODAY AS WE SORT OUT THESE PROBLEMS AND CONSIDER THE APPROPRIATE SOLUTIONS SO THAT WE MAY MOVE FORWARD WITH THIS EXPERIMENT.

AMONG THE PROBLEMS THAT HAVE SURFACED AND NEED TO BE ADDRESSED ARE:

1) BENEFICIARIES SOMETIMES EXPERIENCE LIFE THREATENING DELAYS IN OBTAINING DIAGNOSTIC TESTS AND TREATMENT. TACTICS INCLUDE INTIMIDATION, INADEQUATE PHONE LINES, DELAYS IN MAKING APPOINTMENTS AND DELAYS IN PAYING SUBCONTRACTORS SUCH AS PHARMACISTS.

2) A NUMBER OF HMOS ILLEGALLY SCREEN OUT HIGH RISK BENEFICIARIES.

3) BENEFICIARIES HAVE BEEN DROPPED OUT OF PROGRAMS WITHOUT THEIR KNOWLEDGE, LEAVING THEM AT RISK OF NO CARE OR HIGH OUT OF POCKET EXPENSES.

4) A NUMBER OF HMOS DISCOURAGE USE OF SERVICES AND ACCESS TO MORE COSTLY SPECIALISTS IN ORDER TO REDUCE COSTS.

5) THE HEALTH CARE FINANCING ADMINISTRATION IS EITHER

UNWILLING OR UNABLE TO COMMIT ENOUGH RESOURCES TO RUN AND MONITOR THIS PROGRAM.

I DO NOT ACCEPT THE PREMISE THAT AN EFFICIENTLY RUN HEALTH SYSTEM WILL ULTIMATELY MEAN FEWER SERVICES OR POORER QUALITY SERVICES FOR THE ELDERLY. WHILE IT IS AN APPROPRIATE PUBLIC POLICY GOAL TO REDUCE HEALTH CARE COSTS, WE MUST CAREFULLY SAFEGUARD AGAINST THE INCOMPETENT AND THE UNSCRUPULOUS TO PROTECT THOSE IN OUR SOCIETY WHO ARE MOST VULNERABLE, THE SICK AND THE ELDERLY. WE MUST ACT NOW WHILE THE MEDICARE HMO PROGRAM IS STILL RELATIVELY SMALL BEFORE WE ARE CALLED UPON TO TACKLE ANOTHER BUREAUCRATIC MONSTER OUT OF CONTROL.

MR. CHAIRMAN, I AGAIN CONGRATULATE YOU ON THIS HEARING AND I LOOK FORWARD TO TODAY'S WITNESSES AS THEY OUTLINE POSSIBLE ACTIONS THAT MIGHT BE TAKEN TO ADDRESS THIS CRITICAL ISSUE AFFECTING THE ELDERLY.

PREPARED STATEMENT OF REPRESENTATIVE ROBERT A. BORSKI

Mr. Chairman, thank you for holding this important hearing on Health Maintenance Organizations and the Medicare Program. I want to commend you for all the work you have done to assist our nation's senior citizens and protect the Social Security and Medicare programs.

With the advent of health maintenance organizations (HMOS), our nation has witnessed great changes in the delivery of health care. Many of these new health care delivery systems offer a variety of unique benefits to older Americans. However several plans have also been criticized for misusing the system and ignoring the beneficiaries' concerns.

As you know, health care maintenance organizations act as both insurer and provider of comprehensive but specified services. In the early 70s, Congress evaluated HMOs as a way to save Medicare dollars as well as providing high quality coordinated benefits. By 1982, Congress had set up demonstration projects and authorized the Medicare program to contract with HMOs to cover beneficiaries on a "risk" basis. Under a risk contract, the HMO agreed to provide a full range of benefits in exchange for Medicare's payment of a fixed cost for each enrollee.

Since the inception of the HMO/Medicare program, certain marketing practices, the accessibility of specialized services, and the adequacy of HMO quality assurance have been called into question. On the other hand, the HMOs themselves have raised concerns about the current payment system, overregulation and mechanisms for quality assurance.

As HMOs continue to emerge across the country, the interest of Medicare beneficiaries grows as well. Medicare now represents 7.4% of the total HMO enrollment in the country. Furthermore, about 40% of all HMOs now have contracts with Medicare. Clearly the interest and growth in this program requires us to investigate and proceed cautiously with HMO contracts and Medicare. While I believe HMOs can offer some unique and beneficial services to older Americans, I believe we must ensure that America's senior citizens will receive quality care in an affordable and acceptable delivery system.

Mr. Chairman, thank you again for holding this important hearing and I look forward to hearing the testimony of our distinguished witnesses.

PREPARED STATEMENT OF REPRESENTATIVE LOUISE M. SLAUGHTER

Health Maintenance Organizations are an integral part of our health care delivery system. They have the possibility of being a very important health resource to senior citizens. For senior citizens who enroll in an HMO, there is the expectation that, for reasonable costs, more health services than currently provided by Medicare will be available; that they will be relieved of the burdensome and often confusing task of filling out Medicare claim forms; and that there will be greater access to an improved coordinated health delivery system.

In Rochester New York, a part of the 30th Congressional District which I represent, the three HMOs are financially healthy and providing quality care to thousands of senior citizens. Rochester's HMOs are key to the health provider community, representing about one-third of health insurance market in area. However, all communities may not be as fortunate as Rochester. Florida's recent experience with International Medical Centers raises serious questions about the need for increased federal oversight. Without a clear understanding of the problems that occured in Florida and recommendations for improvement, public confidence in the HMO system is seriously threatened.

It has only been since 1982 that the federal government has provided incentives for HMOs to serve the Medicare population. Yet since that time less than 60% of the HMOs have joined the Medicare HMO program, serving only 10% of the Medicare population.

Medicare HMOs have the promise to provide high quality care for Medicare beneficiaries at reduced costs. Given the importance of Medicare HMOs to seniors it is critical for us to review the experiences of the past few years and to explore ways to strengthen the system to insure that Medicare HMOs are indeed a viable part of quality health care services available to senior citizens. I look forward to hearing from today's panel and about their experiences and recommendations to strengthen the Medicare HMO program.

PREPARED STATEMENT OF REPRESENTATIVE HARRIS W. FAWELL

MR. CHAIRMAN, this hearing provides an opportunity to review what has been a "health care revolution" over the past decade. Health Maintanance Organizations (HMOs), combined with home health care services, skilled nursing facilities, and advanced outpatient services, have created a totally new health care environment. Despite the effects of the Prospective Payment System, this new health care revolution can be the key to quality health care in the future.

Health Maintanance Organizations have expanded greatly over the past decade, providing complete health care for more Americans throughout the nation. The number of HMOs has increased about 900 percent in 15 years, from 39 in 1971 to 600 today, with estimated enrollment of about 24 million people. HMOs provide comprehensive medical care for a prepaid fee to patients who agree to use participating physicians and hospitals. With prepayment, HMOs assume the financial risks associated with health care. For this reason, and because of reports of markedly lower hospital utilization by HMOs, many employers encourage workers to elect HMO coverage as a way to restrain costs.

Federally qualified HMOs receive congressional support through grants and guaranteed loans. They also receive marketing assistance through the HMO Act of 1973, which requires that employers with at least 25 employee offer HMO enrollment as an option if requested to do so by a federally qualified HMO in the geographic area.

A 1984 study conducted by the Rand Corporation found that hospital utilization among HMO members was 40 percent lower than among those with full insurance coverage without cost sharing, using a fee-for-service physician of their choice. Compared to a group with a 5 percent co-payment requirement on services provided by a fee-for-service physician of their choice, hospital utilization among HMO members was 20 percent lower. A study of 12 HMOs by the General

Accounting Office in 1982 found that hospital utilization was 59 percent lower than that of the general population and 38 percent lower than the national Blue Cross average.

We will hear testimony today that should concern us regarding the administration of HMOs. We should not, however, loose sight of the advances that HMOs have created in the health care industry and the need for individualized service that represents the future of health care throughout the nation.

PREPARED STATEMENT OF REPRESENTATIVE RALPH REGULA

Mr. Chairman:

Managed health care systems such as health maintenance organizations, preferred provider organizations and their combinations continue to grow. Notable most recently has been the growth from single state plans to multistate HMOs and rural HMOs.

As the complexity and scope of these health care options broadens the Medicare has come to increasingly rely upon them for benefits to the elderly. In 1985, Medicare enrollment in risk-based HMOs rose by more than 73% to 431,000, and is expected to double in the next two years. During that period the program paid approximately $415 to HMOs. This figure more than doubled in the following six months.

The growing importance of managed care, particularly HMOs, is underscored by questions relating to quality of care and HCFA's regulation of these entities. The National Committee for Quality Assurance and the American Medical Care Review Assocation have reported an increased interest in these systems throughout the United States. As an example, in Washington State, the Rand Health Insurance Experiment Research Group have on ongoing comparative study of health care. Their findings provide a data base on the quality aspects of HMOs, PPOs, and other more traditional types of care.

Since Medicare's capitation payment creates strong financial incentives for the HMO to limit treatment it is essential adequate safeguards are in place to ensure certain levels of care are maintained. Furthermore, there is an ongoing concern regarding access and whether HMOs are selectively avoiding more high risk sections of the population. Issues raised by the Florida HMO demonstration project indicates some of the potential abuses which my occur under this agreement.

Despite these concerns I am convinced managed care can make valuable contributions toward a more efficient system. In Ohio, we have been in the developmental stages of building an effective HMO system. As important, we are interfacing these efforts with a quality assurance program. Much remains to be done but progress is being achieved. A State survey shows that Ohio residents from Cuyahoga County families receiving AFDC who are enrolled in the HMO program are considerably more satisfied with their health services than those receiving private care.

As these increasingly complex systems of care take a larger proportion of the market the federal government must review its regulatory policies. I am confident our distinguished panel of witnesses will assist our Committee today in that difficult task.

PREPARED STATEMENT OF REPRESENTATIVE JIM SAXTON

I WOULD LIKE TO COMMEND THE DISTINGUISHED CHAIRMAN MR. ROYBAL, AND MY GOOD FRIEND FROM NEW JERSEY, MR. RINALDO FOR HOLDING THIS HEARING TODAY TO EXAMINE MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

THERE HAS BEEN AN EXPLOSION OF HMOS ACROSS THE COUNTRY IN THE LAST DECADE. AS DEMONSTRATED BY THE DRAMATIC RISE IN MEDICARE EXPENDITURES FOR HMO SERVICES, IT IS OBVIOUS THAT MORE AND MORE ELDERLY ARE ELECTING TO ENROLL IN HMOS AS AN ALTERNATIVE TO TRADITIONAL FEE-FOR-SERVICE CARE. AND, ON THE WHOLE, HMOS HAVE PROVEN TO BE A COST-EFFECTIVE, QUALITY OPTION FOR MEDICARE BENEFICIARIES.

HOWEVER, AS MANY OF YOU HAVE EXPERIENCED, AND AS AN INVESTIGATION BY THE SENATE SPECIAL COMMITTEE ON AGING HAS DISCOVERED, THERE ARE FLAWS IN THE CURRENT SYSTEM.

ONE PROBLEM I WOULD LIKE TO MENTION THAT SEEMS MOST PREVALENT AND THAT INDIVIDUALS HAVE EXPERIENCED IS THE LACK OF ADEQUATE COMMUNICATION BETWEEN THE HMO AND THE BENEFICIARY.

LAST YEAR, I RECEIVED NUMEROUS CALLS AND LETTERS FROM CONSTITUENTS IN MY DISTRICT REGARDING THEIR HMO. THEY WERE DISTURBED WHEN A PREMIUM WAS IMPOSED UPON THEM AFTER THEY HAD JOINED THE HMO WHEN IT WAS ADVERTISED TO THEM AS "PREMIUM-FREE." THEY FELT, AND UNDERSTANDABLY SO, THAT THE HMO HAD ADVERTISED THE LACK OF PREMIUMS AS A MARKETING Tool TO LURE THEM IN AND ONCE THEY HAD THEM, THEY FELT FREE TO IMPOSE PREMIUMS ON THEM.

IT WASN'T SO MUCH THE AMOUNT OF THE PREMIUM INVOLVED THAT BOTHERED THEM, IT WAS THE FACT THEY THEY NEVER KNEW IT WAS COMING. THERE HAVE ALSO BEEN MISUNDERSTANDINGS OVER WHAT MEMBERSHIP IN AN HMO ENTAILS, ESPECIALLY REGARDING THE LOCK-IN PROVISION. THIS LACK OF APPROPRIATE COMMUNICATION BETWEEN THE HMO AND THE BENEFICIARY WHEN ENTERING INTO A PLAN, OR CONTRACT, WHICH IS HOW I VIEW SUCH AN AGREEMENT, GREATLY REDUCES THE CONFIDENCE AND SATISFACTION THE ELDERLY HAVE IN THEIR HEALTH PLAN. I WOULD LIKE TO SEE STRICTER STANDARDS IMPOSED ON HMOS REGARDING THE INFORMATION BENEFICIARIES RECEIVE TO AVOID THESE SITUATIONS.

I AM GRATEFUL THAT WE ARE HODING THIS HEARING TODAY TO IDENTIFY THE WEAKNESSES OF PREPAID PLANS IN ORDER TO PROTECT THE INTERESTS OF MEDICARE BENEFICIARIES AND THE QUALITY OF THEIR HEALTH CARE. HMOS HAVE THE POTENTIAL TO OFFER A GREAT DEAL TO OLDER AMERICANS. IT IS VITAL THAT WE WORK TOGETHER TO DEVELOP A HEALTH CARE OPTION THAT PEOPLE CAN UNDERSTAND AND RELY ON.

THANK YOU.

PREPARED STATEMENT OF REPRESENTATIVE JIM LIGHTFOOT

I WOULD LIKE TO TAKE THIS OPPORTUNITY TO THANK CHAIRMAN ROYBAL FOR HOLDING THIS HEARING ON MEDICARE HMOs. IT IS VERY TIMELY, CONSIDERING OUR JUST CONCLUDED JOINT HEARING WITH THE TASK FORCE ON THE RURAL ELDERLY ON THE STATUS OF OUR RURAL HEALTH CARE SYSTEM.

IOWA HAS THE FOURTH LARGEST SHARE OF ELDERLY PERSONS IN THE UNITED STATES. OVER 14 PERCENT OF IOWA'S POPULATION IS AGE 65 AND OVER. IN 27 OF IOWA'S 99 COUNTIES, THE ELDERLY COMPRISE MORE THAN 18 PERCENT OF THAT COUNTY'S POPULATION.

THE ELDERLY CONSUME A DISPROPORTIONATE SHARE OF HEALTH CARE SERVICES. THIS IS ESPECIALLY TRUE FOR SUCH CHRONIC ILLNESSES AS HEART DISEASE, ARTHRITIS, HEARING AND VISION IMPAIRMENT, ORTHOPEDIC PROBLEMS, AND DIABETES.

MR. CHAIRMAN, ELDERLY HEALTH CARE NEEDS ARE CHANGING. IN ADDITION TO ACUTE CARE SERVICES, OTHER HEALTH CARE AND SOME SOCIAL AND TRANSPORTATION SERVICES ARE NEEDED TO ALLOW THE ELDERLY THEIR NON-INSTITUTIONAL INDEPENDENCE. THESE NEW SERVICES WILL CREATE FINANCIAL AND BUDGET CHALLENGES FOR THE PUBLIC AND PRIVATE SECTORS.

INCLUDED IN "OTHER HEALTH CARE SERVICES" IS THE MEDICARE HMO. AS WE ALL ARE AWARE, THE HMO CONCEPT BEGAN IN CALIFORNIA. THE FEDERAL OVERSIGHT OF HMOs BEGAN IN 1973, WHILE THE MEDICARE HMO PROGRAM BEGAN AROUND THE SAME TIME. THESE MEDICARE HMOs DID NOT START TO EXPERIENCE MAJOR GROWTH UNTIL THE EARLY 1980's.

COINCIDENTALLY, THIS WAS THE PERIOD OF SOME MAJOR REVISIONS IN THE MEDICARE PROGRAM ITSELF, SUCH AS THE IMPLEMENTATION OF THE DIAGNOSTIC RELATED GROUP (DRG) PROSPECTIVE PAYMENT SYSTEM (PPS) AND THE REGULATION OF THE PRACTICE OF MEDICINE THROUGH THE PEER REVIEW ORGANIZATION (PRO). THESE CHANGES HAVE HAD A DRAMATIC AFFECT ON THE OPERATIONS AND THE FINANCES OF THE AMERICAN HEALTH CARE DELIVERY SYSTEM, BUT ESPECIALLY AS IT EXISTS IN OUR RURAL AREAS. CONSEQUENTLY, THIS SHOULD BE A MAJOR FOCUS OF OUR HEARING TODAY.

ACCORDING TO A RECENT REPORT BY SEN. JOHN HEINZ, THE MEDICARE HMO PROGRAM IS PLAGUED BY "CERTAIN VERY SERIOUS DEFICIENCIES". IN LIGHT OF THE CRITICISMS CONTAINED IN THIS REPORT:

1. WE MUST INQUIRE AS TO THE MARKETING PRACTICES, BOTH QUANTITY AND QUALITY, OF MEDICARE HMOs IN OUR RURAL AREAS.

2. WE MUST DETERMINE WHETHER THE PRESENT ENROLLMENT AND DISENROLLMENT PRO OF MEDICARE HMOs ALLOW THESE HEALTH CARE ORGANIZATIONS TO CARRY MOSTLY HEALTHIER AND MOSTLY LOWER COST ENROLLEES. IF THIS IS ACCURATE, AND YET AT THE SAME TIME THESE HMOs ATTEMPT TO INCREASE THEIR OPERATIONS IN OUR RURAL AREAS, THEN THE LONG-TERM PROGNOSIS FOR OUR RURAL ELDERLY IS SOBERING.

3. WE MUST LOOK INTO THE ADEQUACY OF THE QUALITY OF CARE GIVEN TO OUR ELDERLY DUE TO THE TENDENCY OF HMOs TO REDUCE THE AMOUNT AND THE COST OF CARE GIVEN.
WE MUST ALSO INVESTIGATE THE ELDERLY'S ACCESSIBILITY TO SPECIALIZED SERVICES OFFERED BY HMOs DUE TO THEIR TENDENCY TO ELIMINATE MOST MARGINAL OR COSTLY PATIENTS, SUCH AS OUR RURAL ELDERLY.

4. WE SHOULD ALSO LOOK INTO THE ADEQUACY OF THE GENERAL GRIEVANCE PROCEDURES OF HMOs.

TO BE FAIR, MEDICARE HMOs ARE CONCERNED WITH THE CURRENT PAYMENT SYSTEM, OVERREGULATION, AND AN APPROPRIATE REVIEW SYSTEM TO ASSURE QUALITY. THESE ARE LEGITIMATE AREAS OF CONCERN AND WE SHOULD INVESTIGATE THEM AS WELL.

MR. CHAIRMAN, IF MEDICARE HMOs ARE TO BE AN EFFECTIVE WAY TO PROVIDE LOWER COST, HIGH QUALITY HEALTH CARE FOR MEDICARE BENEFICIARIES, ESPECIALLY OUR RURAL ELDERLY, THEN OUR QUESTIONS WILL SERVE AS A STARTING POINT IN THAT DETERMINATION.

THANK YOU, MR. CHAIRMAN, AND I LOOK FORWARD TO THE TESTIMONY THAT WE WILL HEAR.

PREPARED STATEMENT OF REPRESENTATIVE CONSTANCE A. MORELLA

MR. CHAIRMAN, THANK YOU FOR CALLING THIS HEARING TODAY TO EXAMINE THE MEDICARE HMO PROGRAM AND TO EXPLORE STRATEGIES FOR STRENGTHENING THE MEDICARE HMO PROGRAM.

FOR THE MOST PART, HMOs HAVE PLAYED AN IMPORTANT ROLE IN PROVIDING LOW-COST, EFFECTIVE CARE FOR MEDICARE BENEFICIARIES. HOWEVER, IT IS CLEAR THAT THE FEDERAL GOVERNMENT MUST BE VIGILANT IN ITS OVERSIGHT OF THE MEDICARE HMO PROGRAM. FOR THIS REASON, TODAY'S HEARING SERVES A VERY IMPORTANT PURPOSE.

MR. CHAIRMAN, I APPRECIATE YOUR EFFORTS TO EXAMINE THE MEDICARE HMO PROGRAM, WITH THE FIELD HEARINGS HELD DURING THE LAST TWO YEARS. THERE ARE SOME SERIOUS PROBLEMS WITH FEDERAL OVERSIGHT OF THE PROGRAM, AND I LOOK FORWARD TO WORKING WITH YOU AND THE MEMBERS OF THE COMMITTEE TO ADDRESS THESE CONCERNS.

PREPARED STATEMENT OF REPRESENTATIVE E. CLAY SHAW, JR.

I appreciate having this opportunity to join my colleagues serving on the Select Committee on Aging today to discuss the "Future of the Medicare Health Maintenance Organization Program." I would like to thank Chairman Roybal and Ranking Minority Member Rinaldo for holding this hearing, which is of interest to all elderly Americans. Additionally, I would like to commend my colleague from Florida, Mr. Mica, who has worked tirelessly to ensure that there is proper federal oversight and regulation of a particular South Florida HMO, International Medical Centers (IMC). It is certainly an honor to join all of you who are committed to the preserving the integrity of this federal health care program, despite our recent experiences with IMC.

In the past year, my District Office in Fort Lauderdale, Florida has received numerous complaints from constituents about IMC. These complaints have come from Medicare beneficiaries enrolled in IMC, as well as health care providers treating IMC members. These complaints include quality of care, denial of care, failure to pay bills in a timely manner, and problems with enrollment and disenrollment. I understand that the Health Care

Financing Administration (HCFA) terminated IMC's Medicare contract for non-compliance of one HMO regulation--IMC's failure to increase its non-Medicare enrollment, as required by Medicare statute. I would suggest to the Committee, however, that current law setting out HCFA's routine management, accounting and other oversight functions regarding HMOs is not sufficient to detect this infraction, let alone the other, more serious improprieties occurring in the daily operations of many Medicare HMOs throughout the nation.

I agree that our experience with IMC can serve as an impetus to improving the existing Medicare statutes which comprise the structure of the Medicare HMO program. As many of you may already know, I have written to the Comptroller General of the United States at the General Accounting Office (GAO), the Attorney General of the United States at the Department of Justice (DOJ) and the Administrator of HCFA at the Department of Health and Human Services requesting that thorough investigations of IMC be conducted. Although each of these agencies have ongoing investigations in this matter, I asked that they also evaluate the financial responsibility that the federal government may have incurred as a result of the debts left after the collapse of IMC.

Many IMC members and health care providers tell me that they consider IMC to have the full faith and backing of the federal government because of HCFA's Medicare contract with this HMO. If GAO, DOJ and HCFA determine that IMC was able to misuse or divert Medicare payments, because of inadequate federal regulation, I believe it is imperative that we must redefine the Medicare HMO statutes. IMC's administrative and managerial practices provided little or no accountability between the central office in Miami, Florida and its regional IMC franchises. This so-called "network concept," which has served as a model for HMOs in other regions of the country, makes it almost impossible for HCFA to properly oversee the quality of care, financial solvency and enrollment percentages.

I am considering introducing legislation which would specify the manner in which a federally-approved HMO distributes Medicare

funds to its non-federally-approved franchises. In this way, we can account for the proper use of federal Medicare funds throughout loose HMO networks. This oversight would help protect the rights of both HMO members and health care providers that participate in the HMO program.

Finally, this and other legislative and regulatory measures discussed today would reaffirm the federal government's commitment to the concept of risk contract HMOs. I agree that the HMO health care concept is a good one. I intend to continue to work with my colleagues on this Committee and my colleague from Florida Mr. Mica, to improve and strengthen the Medicare HMO program because it can be an efficient, cost-effective method of health care delivery which is desperately needed by elderly Americans across our nation.

STATEMENT OF THE HONORABLE DAN MICA, A MEMBER OF CONGRESS FROM THE STATE OF FLORIDA

Mr. MICA. Thank you, Mr. Chairman. Let me just start out by taking a special moment to thank you for authorizing the hearings that began a national review of HMOs in the United States. I fully appreciate your graciousness in the way that you have handled this and the latitude that you've allowed the committee. As you mentioned earlier, Mr. Rinaldo and Mr. Boucher both participated in the hearing. The staff has been phenomenal. The staff has done an excellent job. And I think together this committee has taken a leadership role in the Congress and I believe it will be a new, expanded and continuing role in overseeing HMOs and HMO concepts in the United States. I would like to start out, because there has been so much emotion and so much negative comment about HMOs in the United States and particularly in our State of Florida in the last year or two, to say that I endorse the concept of HMOs. I hope that this Congress, this country, continues to pursue this type of concept, whether or not we have to add regulations or modify or assist in some way its development. Because the concept has indeed worked.

I might also say to my colleagues and for the record, it's not been easy. I want to commend my staff for their fortitude: they helped me to maintain an aggressive role in this. I've been a Member of Congress for 10 years and have worked on the Hill now for 20 years. But we were harassed, we were intimidated, we were questioned, we were warned, we were asked to drop this review. And sometimes I guess our sanity in even approaching the question or speculation that would question an organization that was drawing $400 million a year in Federal Government payments, was a difficult situation for us to face.

We're glad we stuck with it. Many times we almost dropped it thinking it was a little too much for us to get involved with. I would like to at this time ask for permission to submit my entire statement in the record and I will try to summarize.

Mr. Chairman, first I'd like to offer one additional special thanks to my senior staff for the work and the hours that they've put into this over the last 3 years. As some of the Members may know, the particular HMO we've been investigating has had two of its senior management CEO indicted in the last few weeks. There are more indictments expected. Without the work that we have all put into this, and as I indicated, particularly may senior staff here, I don't think some of this would have happened. And I appreciate that.

We held hearings under the auspices of this committee in July of 1984 [1] and in April of 1986 [2], regarding complaints my office got on HMOs in South Florida. I might say at the outset that we thought that each time we would just slap the HMO's on the wrist, tell them to get their act together and proceed. But as we got deeper into this, we found there were deeper problems. We had thousands

[1] Health Maintenance Organizations and the Elderly: Promises, Problems and Prospects, July 9, 1984. Comm. Pub. Nbr. 98-469

[2] Health Maintenance Organizations and the Elderly: Promises, Problems and Prospects, Part II, April 1, 1986. Comm. Pub. Nbr. 99-577. Both publications are available from the Select Committee on Aging but the supply is very limited.

of complaints. It quickly emerged in our area that only one HMO was the subject of almost all if not all of the complaints that were leveled at our office concerning HMOs. That was International Medical Centers. That incidentally was the largest Federally certified HMO in the United States drawing, at its peak, $36 million a month in payments from the Federal Government. IMC generated literally thousands of complaints. We brought these complaints to the attention of HCFA and the Florida Insurance Commissioner's office. The Inspector General also moved into the picture, and the FBI, and as we now know, the Racketeering Division of the Department of Labor moved in.

We first had an indication of these problems with IMC about 2 years ago on nonpayment of claims. And I might just give one example of what happened.

In our testimony before this committee, we originally were told 5,000 records had been lost because of a computer error and therefore they could not be paid. We were later told that it wasn't 5,000 but 50,000. We were then told that they may have been accidentally shredded. Finally, a lawyer was sent to Washington to discuss the issue with my staff and we were told that the records fell off the back of a truck and that's the last we've heard of those 50,000 records, or 5,000 records. When a federally qualified HMO gives that kind of an explanation for not paying its bills to a Congressional committee, I think it warrants some second review.

I don't want to focus only on the financial aspects of IMC's failure. We have profound concerns about the consistency and quality of the health care that they provided. We have stacks of complaints in our office that IMC members and former members sent to us, stories of people who feel they were deprived of care, feel they were simply neglected, simply overlooked by the system. These complaints range from IMC members who time and time again couldn't get appointments with their doctors, or could not get the appropriate referrals to specialists, to horror stories of cancer patients whose illnesses were not detected until too late, relatives who told us of premature death because of improper treatment, lawyers who came in and told us they have cases that were filed regarding improper treatment.

I have one case and I have it right here, of a constituent who had surgery approved by IMC, was prepared for the operation, in the hospital and prepped and ready to be operated on, and the surgeon told the doctor, "because of IMC's record, no operation until I get the money first." Here is a prepaid health plan: no operation until we get the money first. There are more stories. I won't read them all.

Originally, IMC was getting up to $36 million a month. Then $30 million a month. But there is also a problem that we saw with what we call a catch-22. We went through a year of reviewing these problems. We knew the financial insolvency was there. And one conversation I had with our insurance commissioner, who will testify here today, and representatives from the Federal Government, from HCFA, went something like this: Can the State move in? The State said no, we cannot move in because they're not insolvent. HCFA is going to give them $30 million for this month's pay-

ment. So we can't move in. And HCFA cannot withhold the payment because the State wouldn't move in.

And here we had a dilemma, a catch-22, for each agency. Now, it may be in the purview of this committee to say that we're going to recommend changes in the Federal law so that HCFA can move and move quicker or in concert with the State insurance commissioner, and Insurance Commissioner Gunter may tell you about some changes in State law that would prevent this in the future. But I think that needs to be addressed.

I might also just add as an aside that as IMC folded just last month and the State did move in, the estimates ranged from $20 to $40 to as much as $100 million that will be left owed to doctors, hospitals, and providers for patient care, as they fold, after they've drawn this $30 million a month.

I might also add that we need to look at the structure of HMOs in the future. I'm introducing today legislation that will complete the 2-year study. We originally had 13 points that we had covered in this investigation that we thought should be addressed. Last year we were able to include in the medicare authorization seven of those points. The other six are incorporated in the new legislation. I'd like to also submit that for the record, and maybe the committee would see it as appropriate to recommend all or portions of this legislation to the appropriate committees.

I might also indicate that we need to make sure that in the future the solvency of an HMO is appropriately assessed on a monthly or quarterly basis, so that we don't get into this situation again. There were different times where as much as $10 million, $14 million was required to be injected into this HMO to keep it financially solvent. We think to let it get to that point also is a tremendous problem.

Mr. Chairman, I'm trying not to read all of this statement. Let me just close with these final remarks.

IMC has been purchased by a national organization in the last 10 days called Humana. I think that purchase is a positive step. Humana, I understand, has a long history of providing quality health care for South Florida. Now part of the major Federal effort on HMOs is temporarily off the hook. But we must continue to hold Humana or any other health care provider working with HMOs responsible for quality health care, for efficiency in operation, and to abide by the Federal laws. We may have to pass additional laws. We can't tolerate a reoccurrence of the IMC panic in this Nation where millions of people are moving toward HMOs.

We cannot now or in the future permit the lives or the wellbeing of our people to fall victim of the profit motive gone berserk. Finally, I don't think we can relax our vigilance, and indeed I think we need to increase vigilance from this committee, from HCFA, from the Federal Government and from the State government, as a larger and larger percentage of the United States population move into HMOs, a concept that I started out by saying I believe has worked, can work and I hope we can make it work better in the future.

I thank the committee.

[The prepared statement of Mr. Mica follows:]

PREPARED STATEMENT OF REPRESENTATIVE DAN MICA

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I WOULD LIKE TO FIRST OF ALL THANK YOU FOR GRANTING ME THE OPPORTUNITY TO COME BEFORE YOU TODAY TO TESTIFY TO MY EXPERIENCE, AND THE EXPERIENCE OF THOSE I REPRESENT, WITH HEALTH MAINTENANCE ORGANIZATIONS IN SOUTH FLORIDA. I WILL KEEP MY COMMENTS BRIEF.

I HELD HEARINGS IN FLORIDA UNDER THE AUSPICES OF THIS COMMITTEE IN 1984 AND, AGAIN, IN APRIL OF 1986, TO EXAMINE CONTINUING COMPLAINTS REGARDING HMO OPERATIONS IN MY AREA. I HAD INTENDED THE HEARINGS TO REVIEW THE CARE AND OPERATIONS OF ALL REGIONAL HMOS. BUT LAST YEAR IT QUICKLY EMERGED THAT ONE HMO -- INTERNATIONAL MEDICAL CENTERS -- GENERATED FAR MORE COMPLAINTS OF A SERIOUS NATURE THAN OTHER LOCAL HMOS. THE HEARING BECAME A REVIEW OF IMC, AND THE ISSUES WHICH SURFACED PROMPTED ME TO IMMEDIATELY ENLIST THE AID OF THE HEALTH CARE FINANCING ADMINISTRATION, THE FLORIDA INSURANCE COMMISSIONER, THE INSPECTOR GENERAL AND THE FBI IN AN INVESTIGATION OF IMC'S PRACTICES.

THE FIRST INDICATION I HAD THAT IMC'S PROBLEMS WOULD NOT BE EASILY RESOLVED, WAS THEIR EXPLANATION FOR AN OVERWHELMING INCREASE IN COMPLAINTS ABOUT THEIR NON-PAYMENT OF CLAIMS. THE PREVIOUS FALL, MY OFFICE HAD BEEN INUNDATED WITH COMPLAINTS THAT IMC WAS NOT PAYING THEIR CLAIMS. IMC TESTIFIED THAT 5,000 CLAIMS HAD BEEN LOST DUE TO A COMPUTER GLITCH. I WAS LATER APPROACHED OUTSIDE OF THE HEARING ROOM BY AN IMC EMPLOYEE AND WAS TOLD THAT THE NUMBER OF CLAIMS LOST WAS 50,000, NOT 5,000 -- AND THAT THESE CLAIMS HAD NOT BEEN LOST DUE TO COMPUTER ERROR BUT HAD, IN FACT, BEEN DELIBERATELY DESTROYED. AN ATTORNEY REPRESENTING IMC LATER CAME TO ME IN WASHINGTON AND TOLD ME THAT THESE CLAIMS HAD NOT BEEN LOST OR SHREDDED! THEY HAD FALLEN OFF THE BACK OF A TRUCK.

WHEN A FEDERALLY QUALIFIED HMO GIVES THIS KIND OF EXPLANATION FOR WHY THEY HAVEN'T BEEN PAYING THEIR BILLS, YOU BECOME CONCERNED ABOUT THE REST OF THEIR OPERATION.

I DO NOT WANT TO FOCUS ONLY ON THE FINANCIAL ASPECTS OF IMC'S FAILURE. I HAVE PROFOUND CONCERNS ABOUT THE CONSISTENCY AND QUALITY OF CARE IMC PROVIDED. I HAVE STACKS OF COMPLAINTS IN MY OFFICES FROM IMC MEMBERS AND FORMER IMC MEMBERS -- STORIES OF PEOPLE WHO FEEL THEY WERE DEPRIVED OF CARE, OR WHO FEEL THEY WERE SIMPLY NEGLECTED. THESE COMPLAINTS RANGE FROM THE IMC MEMBERS WHO TIME AND TIME AGAIN COULD NOT GET APPOINTMENTS WITH THEIR

DOCTOR OR REFERRALS TO SPECIALISTS, TO HORROR STORIES: STORIES OF CANCER NOT DETECTED UNTIL TOO LATE, STORIES OF PATIENTS WAITING IN HOSPITAL EMERGENCY ROOMS FOR URGENT MEDICAL ATTENTION.

I HAVE A CASE HERE OF ONE CONSTITUENT WHO HAD HIS SURGERY APPROVED BY IMC. HE WAS PREPPED FOR THE OPERATION WHEN THE ATTENDING SURGEON TOLD HIS DAUGHTER THAT HE WOULD NOT PERFORM THE OPERATION UNTIL HE RECEIVED, UP FRONT, PAYMENT FOR THE SURGERY. THE DOCTOR HAD EXPERIENCED SUCH DIFFICULTY IN GETTING REIMBURSEMENT FOR SERVICES PROVIDED TO IMC MEMBERS THAT HE NO LONGER TRUSTED IMC TO PAY HIM EVEN IF THEY HAD ALREADY APPROVED THE OPERATION.

THESE ARE STORIES THAT NEED TO BE TOLD, AND I HAVE REQUESTED THAT THIS COMMITTEE, THE WAYS AND MEANS COMMITTEE, AND THE COMMITTEE ON ENERGY AND COMMERCE CONVENE HEARINGS TO EXAMINE THE IMC SITUATION MORE CLOSELY.

AT THE TIME OF ITS CONTRACT TERMINATION, IMC RECEIVED ABOUT $30 MILLION A MONTH -- THAT'S $360 MILLION ANNUALLY -- AND SERVED OVER 130,000 MEDICARE BENEFICIARIES. IN A TIME OF DEEP CONCERNS OVER BUDGET DEFICITS, WE OWE IT TO THE AMERICAN TAXPAYER AND MEDICARE BENEFICIARIES IN HMOS NATIONWIDE, ALL 867,000 OF THEM, TO SEE THAT THE FEDERAL INVESTMENT IN HMOS IS SPENT RESPONSIBLY. I BELIEVE THAT HEALTH CARE PROFESSIONALS HAVE A RIGHT TO MAKE A PROFIT, BUT I FIND MANY OF THE FACTS SURROUNDING IMC'S TERMINATION DISQUIETING, TO SAY THE LEAST.

A REPORT ISSUED BY THE GENERAL ACCOUNTING OFFICE IN 1986 CONCLUDED THAT HMOS COULD RECEIVE 5% LESS IN FEDERAL REIMBURSEMENT PAYMENTS AND STILL EARN A PROFIT. GAO CONCLUDED, IN FACT, THAT UNLESS THE GOVERNMENT INSTITUTED THIS CHANGE IN REIMBURSEMENT, PLANS TO SAVE MONEY BY PROMOTING HMOS WOULD FAIL: WE WILL END UP SPENDING MORE, NOT LESS. IF THESE CONCLUSIONS ARE TRUE, IMC HAS RECEIVED $1.5 MILLION IN EXCESS PROFITS MONTHLY. I FIND THIS APPALLING WHEN I CONSIDER THE HUNDREDS OF CASES IN MY OFFICE FROM IMC MEMBERS NOW STUCK WITH UNPAID BILLS. MANY OF THESE PEOPLE ARE ELDERLY, AND THEY ARE DUNNED AGAIN AND AGAIN FOR PAYMENT FOR SERVICES FOR WHICH THEY ARE, UNDER FLORIDA STATE LAW, NOT LIABLE. ONE HOSPITAL IN MY DISTRICT IS OWED ONE MILLION DOLLARS BY IMC.

I AM FURTHER APPALLED WHEN I READ REPORTS THAT THE IMC'S FISCAL CHAOS WAS DUE IN LARGE PART TO EXCESSIVE ADMINISTRATIVE COSTS, HIGH SALARIES, AND COSTLY MARKETING STRATEGIES. WHILE IMC

EXECUTIVES RODE IN COMPANY LIMOSINES, SENIOR CITIZENS AND CREDITORS WENT UNPAID.

SHORTLY AFTER THE HEARINGS I HELD IN 1986, HCFA DEMANDED THAT IMC INFUSE $9.1 MILLION INTO THE COMPANY TO INSURE THEIR FINANCIAL SOLVENCY. IN FEBRUARY, AS PART OF A PROPOSAL TO BUY IMC OUT, HUMANA CORPORATION BOUGHT $5 MILLION IN IMC STOCK. IN APRIL OF THIS YEAR, HCFA DEMANDED THAT IMC INFUSE $5 MLLION INTO THE COMPANY TO AGAIN INSURE THEIR FINANCIAL SOLVENCY.

MR. CHAIRMAN, IMC HAS BEEN CHARACTERIZED AS HAVING A "SLOPPY MANAGEMENT STYLE." HOWEVER, IF IT WAS NECESSARY FOR THIS IMMENSE AMOUNT OF CAPITAL TO BE PUMPED INTO THE SYSTEM WHILE IMC CONTINUED TO RECEIVE $30 MILLION IN FEDERAL MONIES A MONTH, AND IF THIS FISCAL CHAOS CONTINUED WHILE THE GOVERNMENT AND THE STATE RECEIVED HUNDREDS OF COMPLAINTS ABOUT THE KIND OF CARE IMC WAS GIVING ITS MEMBERS, I ASK YOU: WHO WERE THE SLOPPY MANAGERS? IMC, OR OUR GOVERNMENT AGENCIES?

WE MIGHT CONCLUDE THAT BOTH ARE AT FAULT. HOWEVER, I QUESTION WHETHER THE AGENCIES HAD THE PROPER TOOLS TO DEAL WITH THE SITUATION. WHAT I WAS TOLD WAS THAT WE HAVE FEW OPTIONS TO DEAL WITH HMOS WHO FALL OUT OF COMPLIANCE, OTHER THAN TO DECERTIFY THEM.

LET ME OFFER ONE EXAMPLE OF THE CATCH-22 SITUATION THAT, I THINK, CHARACTERIZES THIS BUREAUCRATIC NIGHTMARE.

AS IMC HOVERED ON THE BRINK OF INSOLVENCY, FOLLOWING THE TERMINATION OF ITS CONTRACT BY HCFA, I CARRIED ON A THREE-WAY PHONE CONFERENCE WITH HCFA, COMMISSIONER GUNTER'S OFFICE AND OUR CONGRESSIONAL OFFICE. THE COMMISSIONER EXPLAINED THAT HIS PEOPLE WERE READY TO MOVE IN, BUT COULD NOT, BECAUSE IMC WAS NOT INSOLVENT. WHY NOT? BECAUSE HCFA WAS GOING FORWARD WITH A $30 MILLION MONTHLY PAYMENT ON FRIDAY. HCFA COMPLAINED THAT THEY HAD TO PROCEED WITH THE $30 MILLION PAYMENT ON FRIDAY. WHY? BECAUSE THE COMMISSIONER WOULD NOT MOVE IN.

AS CLEAR A CATCH-22 SITUATION AS ONE IS LIKELY TO SEE.

THAT IS ONE REASON WHY, IN THE 13-POINT HMO REFORM PACKAGE I INTRODUCED IN THE LAST CONGRESS, I PROPOSED GRANTING FEDERAL AUTHORITIES THE ABILITY TO IMPOSE CIVIL MONETARY FINES FOR DENYING PROPER CARE. THAT IS NOW A LAW, AS WELL AS SIX OTHER MEASURES IN THAT PACKAGE, INCLUDING PROMPT PAYMENT REQUIREMENTS AND NEW GRIEVANCE PROCEDURES.

TODAY, MR, CHAIRMAN, I AM AGAIN INTRODUCING THE REMAINING SIX PROVISIONS. THEY ARE AIMED AT ENHANCING FEDERAL OVERSIGHT OF

HMOS AND, SPECIFICALLY, ADDRESS THE FINANCIAL SOLVENCY OF THESE ORGANIZATIONS. THE BILL WOULD REQUIRE THE AGENCIES WITH OVERSIGHT RESPONSIBILITY TO MAKE A GREATER EFFORT TO MONITOR THE FISCAL HEALTH OF AN HMO'S AFFILIATES; IT WOULD MAKE IT ILLEGAL FOR HEALTH CARE SERVICE PROVIDERS TO DUN HMO MEMBERS FOR PAYMENT FOR SERVICES; IT WOULD REQUIRE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO STUDY THE QUALITY OF CARE PROVIDED TO HMO MEMBERS AS COMPARED TO THE KIND OF CARE OFFERED BY OTHER HEALTH PROVIDER STRUCTURES.

LET ME CLOSE WITH THIS REMARK: I BELIEVE THE HUMANA PURCHASE OF IMC IS A POSITIVE STEP. HUMANA HAS A LONG HISTORY OF PROVIDING QUALITY HEALTH CARE.

BUT WHETHER THE OWNER IS IMC OR HUMANA OR ANY OTHER COMPANY, I WILL CONTINUE TO HOLD ITS MANAGEMENT ACCOUNTABLE TO THE SENIOR CITIZENS OF SOUTH FLORIDA.

- WE CAN TOLERATE NO RECURRANCE OF THE IMC PANIC.
- WE CANNOT NOW OR IN THE FUTURE PERMIT THE LIVES AND WELL-BEING OF OUR PEOPLE TO FALL VICTIM TO THE PROFIT MOTIVE GONE BERSERK.

...AND FINALLY

- WE CANNOT RELAX OUR VIGILANCE UNTIL QUALITY HEALTH CARE IS A RIGHT RATHER THAN A PRIVILEGE FOR ALL OLDER AMERICANS...FOR ALL AMERICANS.

100TH CONGRESS
1ST SESSION

H. R. 2675

To amend title XVIII of the Social Security Act to improve the quality of services furnished by health maintenance organizations and competitive medical plans to medicare beneficiaries, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 11, 1987

Mr. MICA introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

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A BILL

To amend title XVIII of the Social Security Act to improve the quality of services furnished by health maintenance organizations and competitive medical plans to medicare beneficiaries, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare HMO/CMP Quality Improvement Act of 1987".

SEC. 2. PENALTY FOR IMPROPER BILLING OF BENEFICIARIES.

(a) IN GENERAL.—Section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

"(j)(1) Any individual or person who—

"(A) pursuant to an agreement with an eligible organization, furnishes services to an individual enrolled under this section in return for payment from the organization for such services, and

"(B) knowingly charges or bills the individual for amounts for which the organization is liable under such agreement,

is subject to a civil money penalty of not more than $2,000 with respect to each such individual charged or harassed and is subject to being barred from participation in the program under this title for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1862(d).

"(2) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (1) in the same manner as they apply to a civil money penalty under that section.

"(3)(A) The Secretary may not bar an individual or person pursuant to paragraph (1) if the individual or person is

a sole community provider or sole source of essential specialized services in a community.

"(B) The Secretary shall take into account access of beneficiaries to necessary services for which payment may be made under this title in determining whether to bar an individual or person from participation under paragraph (1).

"(C) The Secretary may, out of any civil monetary penalty or assessment collected from an individual or person pursuant to paragraph (1), make a payment to a beneficiary under this title in the nature of restitution for amounts paid by such beneficiary to the individual or person for which the beneficiary is not liable under this section.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts charged or billed on or after the date of the enactment of this Act.

SEC. 3. COOPERATION WITH STATE OFFICIALS IN MONITORING COMPLIANCE WITH REQUIREMENTS.

Section 1876 of the Social Security Act, as amended by section 2(a) is further amended by adding at the end the following new subsection:

"(k) In monitoring compliance of eligible organizations with contracts under this section in meeting the requirements of this section and under such contract and in taking action with respect to failure of such an organization to comply with such requirements, the Secretary shall consult with appropri-

ate State officials for the purpose of assuring coordination of their actions with respect to such monitoring and taking actions for failure to comply with such requirements.".

SEC. 4. TREATMENT OF CERTAIN NETWORK AFFILIATES.

(a) IN GENERAL.—Section 1876 of the Social Security Act, as amended by sections 2(a) and 3, is further amended by adding at the end the following new subsection:

"(l)(1) In the case of an eligible organization which has entered into a risk-sharing contract under this section and which provides for the furnishing of services under the contract through a network affiliate (as defined in paragraph (2))—

"(A) the Secretary shall require the agreement between the organization and the affiliate to have such terms as may be necessary to insure the delivery of quality health care services by the affiliate and to insure sound fiscal management of the affiliate;

"(B) if the organization is not described in subsection (b)(1), the organization must have made adequate provision against the risk of insolvency of the affiliate, which provision is satisfactory to the Secretary;

"(C) the financial status of the affiliate may be taken into account in determining the financial status of the eligible organization; and

"(D) the provisions of subparagraphs (A), (C) and (D) of subsection (i)(3) shall also apply to the network affiliate.

"(2) As used in paragraph (1), the term 'network affiliate' means, with respect to an eligible organization, an entity which has entered into an agreement with the eligible organization under which—

"(A) the entity is compensated by the organization in the manner described in subsection (b)(2)(B), and

"(B) the entity assumes responsibility, with respect to identified enrollees, for patient care with respect to substantially all physicians' services (including primary care services and specialist services) and some institutional services for which the organization is responsible for furnishing to such enrollees under the contract.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 1988.

SEC. 5. STUDY OF UTILIZATION AND QUALITY OF SERVICES FURNISHED BY MEDICARE HMOS AND CMPS.

The Secretary of Health and Human Services shall provide, through a contract with an appropriate organization, for a study of the extent of utilization of services, and the quality of such services, furnished by eligible organizations under

risk-sharing contracts under section 1876 of the Social Security Act (or comparable demonstration projects), or by others under an agreement with such an organization, to medicare beneficiaries enrolled under such section. Such study shall examine services furnished by at least 5 eligible organizations and shall examine services furnished by each such eligible organization which both (1) has enrolled at least 100,000 medicare beneficiaries and (2) has had a waiver of the requirement of section 1876(f)(1) of such Act. The Secretary shall submit to Congress, by not later than January 1, 1989, the results of such study.

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The CHAIRMAN. Thank you, Mr. Mica. I would like to, if you don't mind, have some of your points clarified.

Mr. MICA. Certainly.

The CHAIRMAN. But before we do that, I'd like to ask if you'd be so kind as to send a "Dear Colleague" letter to each member of the committee and enclose your proposed bill.

Mr. MICA. We would be happy to do that, Mr. Chairman.

The CHAIRMAN. What I had in mind was strictly with regard to the authority that the Federal and State authorities have in aggressively enforcing the Medicare demonstration of risk contracts. Is there a lack of aggressiveness on the part of both the Federal Government and the State governments?

Mr. MICA. Of course, Mr. Chairman, I'm only speaking now of the incident in Florida. I think that since HMOs are a new concept at least in the Federal sense and they started out recently as a demonstration project, that there probably is a lack of regulation law and a lack of legislative history to write that law with regard to problems we've had in State and Federal coordination. At one point in one of the original hearings, we had a sense that the Federal Government was throwing up its hands saying my gosh, I can't believe the figures we're hearing; we thought the State was checking this. The State, throwing up their hands and saying we thought the Federal Government was checking this. So there may indeed have to be a review of the laws coordinating these agencies.

Now, more recently, our State has had a legislative session regarding HMO's, and I understand Mr. Gunter will address that issue.

The CHAIRMAN. That was precisely what has been worrying me with regard to the whole problem, and that is the almost complete lack of management. But first of all I wanted to establish whether or not there is a complete lack of management nationwide. I sometimes suspect that that is the case in many States. Now, the other thing that I had in mind to ask was with regard to your statement, and I'm looking for it now, where you say that IMC has been characterized as having a sloppy management style. It was necessary for this immense amount of capital to be pumped into the system, while IMC continued to receive $30 million in Federal monies a month.

Now, it was known that this was a sloppy system. Still, $30 million went into this sloppy system a month. Again, was there no oversight?

Mr. MICA. Mr. Chairman, very respectfully, referring to the Federal oversight, I think the Congress took the lead in this role. I think HCFA could have done a better job. Maybe the new team on board is doing a better job. But I was very kind when I said sloppy. The recent audits have indicated that they were paying their management four to five times the national average for similar duties. At one point it was uncovered that all of the senior management were driving new Mercedes and had yachts, memberships in clubs. It was a very expensive, exclusive operation at the top.

While they were driving the new cars and buying the yachts and all these perks, the bills weren't being paid.

The CHAIRMAN. Well, sloppy in many respects. The Chair will recognize Mr. Biaggi.

Mr. BIAGGI. Thank you, Mr. Chairman. I have an opening statement. Mr. Bonker, because of a conflict in his schedule, is unable to return to the hearing this morning and I ask unanimous consent to have both his and my statement introduced into the record.

The CHAIRMAN. Without objection, it will be so ordered.

Mr. BIAGGI. I would like to comment briefly. From the New York perspective, in February of 1986, I, as Chairman of the Subcommittee on Human Services in the Committee on Aging, held a hearing with relation to HMOs and learned a great deal. We knew that a great deal more had to be pursued.

As a matter of fact, I visited the headquarters of IMC. I spent several hours there with Congressman Larry Smith of your State and clearly, it's a monumental undertaking.

There were some questions, but due to limitations of time, as we all understand in the Congress, the oversight capability of the Congress hasn't been all that great generally speaking. You're to be commended—commended for your persistence, commended for your ability to pursue and also for your courage in not falling victim to the threats, blandishments, and harrassments. But you've done a yeoman's service, you and your staff.

We also place a special purpose in the Select Committee on the Aging.

I'm proud to be a colleague of yours and I commend you once again for your laudable work.

The CHAIRMAN. Thank you, Mr. Biaggi. Mr. Fawell.

Mr. FAWELL. The only question I have is, there is, I assume, standard auditing procedures by HCFA. Why wasn't this uncovered and could it possibly be that there are other such HMOs out there of which we know nothing?

Mr. MICA. Well, first, I think that alludes to the Chairman's question, was there enough oversight from the State and Federal Government. And I think that at one point the State thought the Federal Government was carrying out some of the duties, and the Federal Government thought the State was. But I should tell the committee that even simple procedures like HCFA review were problematic. In one case an individual was sent down to check on IMC. Shortly thereafter, he went to work for IMC. When one of the major eight accounting firms sent in an outside auditor, the chief auditor, as he finished his report, went to work for IMC. When Federal officials went down to look at IMC, they got a great suntan and a new job. We have had this problem, in addition to whatever rules and regulations were in place. We had a situation where it appears, and this is a subject for the courts to determine, that people who may have found a problem with IMC were coaxed into staying and going to work for IMC.

And this has been, incidentally, a subject of a great deal of questioning in the Florida press, and I understand the Washington press is looking at that.

Mr. FAWELL. So you're saying that the oversight wasn't worth a heck of a lot.

Mr. MICA. Well, at least in that period of time when this problem was growing, it doesn't appear to be. There's a newer team that's been working on this that I think has done a much better job.

Whether or not they have all the tools they need is a subject for this committee to debate, and the subject of my legislation.

Thank you.

The CHAIRMAN. Mr. Kennedy.

Mr. KENNEDY. Thank you, Mr. Chairman. Mr. Mica, you've done a tremendous job in serving your constituents and hearing their complaints. When you have that many people that are being hurt, it seems that being a Congressman and picking up on those issues and following up, is really serving the needs of your constituents.

I was, a couple of years ago, involved in looking at establishing an HMO up in Massachusetts. And one of the conclusions that I came to in looking at them was that while HMOs have a tremendous appeal at the get-go, that is, as the HMO fills up and more and more people enter that system, that they have not really gotten to the root cause of ratcheting down medical and health care costs in this country. My concern at the time was that we could have kind of an operation at the nonprofit corporation that I was running that could pull in lots of money for a period of maybe 8 or 10 years. But at the tail end of that, once you've filled up your quota, that because you hadn't ratcheted down any health care costs, then you might have either promised the provision of drugs for instance or private health care services, maybe you've skimmed the cream of the population to exclude certain senior citizen categories and the like. But essentially you're going to end up with a health care category of individuals that were 10 years older, were becoming more sick, and therefore your cost structure was going to go way up.

And I wonder whether or not you've drawn any conclusions about the whole cost structure of HMOs and whether or not we're going to be able to not just see this on an accountant's piece of paper, but whether or not we can draw any major conclusions about where HMOs are leading the health care delivery system in this country.

Mr. MICA. Certainly. But before I address costs, let me just mention one point.

I am very proud of the work that we did in Florida, and this problem was found throughout a good portion of South Florida, not just my district. We're pleased that we had the chance to represent our constituents well. But you know, an administration, a Presidential administration about 6 or 8 years ago said it would be our goal to see 80 percent of America on HMOs by 1990. The present administration and many in this country would like to see most of the seniors of this country moved into an HMO. So while I think we've focused on a problem, we are in a sense ahead of the curve. And if we address this problem, some of the greed and some of the insufficient regulations, some of the problems we saw there, we can address the problem and nip it in the bud that will essentially affect every district in this Nation, because I think the movement will be towards HMO or an HMO-like concept.

Now, with retard to cost. Absolutely, if you go to an HMO strictly and totally with seniors, statistics have indicated that senior citizens, over the age of 62, need five times the health care of anyone under the age of 62. And for everybody the first year at 62, 10 years later they're 72, and at 72 that five times goes up to 40 or 50

times. That's why the original legislation said you just have a 50–50 breakdown of membership. No more than 50 percent medicare. You need to go out in the community and get those businesses and get those governmental entities and those young people involved so it balances out so that doesn't happen.

A fatal flaw in IMC was that they were given, I think at least once, maybe twice or three times, a waiver in the 50–50. Only two in that Nation got that waiver. Both have now failed.

Mr. KENNEDY. No more questions.

The CHAIRMAN. Mr. Erdreich.

Mr. ERDREICH. Thank you, Mr. Chairman. I don't have any questions. I just want to compliment Mr. Mica for what he has done and brought these problems not just to our attention but to the country's. My own State is going through a look-see at a potential HMO structure, and I daresay that many of the concerns that you went through in Florida are some of those that we share in Alabama. So I thank you for what you've done and I think it will be very valuable for all seniors in the future. There's no question, more and more alternatives such as HMOs are provided for senior citizens.

I thank the gentleman.

The CHAIRMAN. Thank you. Mr. Clarke.

Mr. CLARKE. Thank you, Mr. Chairman.

I was very impressed with the courageous and effective work that Representative Mica has done in Florida. And I just have one question. I'd like to ask Mr. Mica if there was a negative effect on other HMOs in Florida as a result of the discoveries of your staff and your committee?

Mr. MICA. Yes, sir. I might tell you that obviously this generated a great deal of public and press attention. I believe, and these figures are close, that at one point IMC had 200,000 seniors as members. When this started to occur, enrollment went down to somewhere around 130,000 and other HMO's have had enrollment problems. And maybe that's one more reason why I should say this. Kaiser-Permanente in California, HMO's in Boston, at Georgetown, throughout this Nation, millions of people are very happy with HMOs. It can work. But you have to be careful. And in this case, where greed took over, or where insufficient oversight allows problems to occur unchecked, HMO's can be disastrous.

We have been told that there will be dozens if not hundreds of malpractice suits filed where people have been maimed or died because of the problems resulting from the IMC failure and the IMC operation.

Mr. CLARKE. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Clarke. Mr. Mica, I would like to thank you on behalf of the committee for some excellent testimony. Since you were the Chairman of the first committee that went out to look into this subject matter, I'd like to invite you to sit as co-chairman of this hearing at this time.

Mr. MICA. Thank you, Mr. Chairman.

The CHAIRMAN. Ladies and gentlemen, our first outside witness for today's hearings, will be Dr. William Roper, who is the Administrator of the Health Care Financing Administration. In addition to his other responsibilities, Dr. Roper has responsibility for the

medicare HMO program and has been actively involved in the solving of problems with IMC. Dr. Roper, we look forward to hearing your testimony, especially on the new legislative proposal for immediate sanctions and the new prepaid health plan models.

Will you please proceed in any manner that you may desire?

TESTIMONY OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Dr. ROPER. Thank you, Mr. Chairman and members of the committee. I am pleased to have the opportunity this morning to discuss medicare's experience with HMOs, health maintenance organizations, and competitive medical plans, or CMPs. Beneficiaries who have chosen this option are receiving high quality care and more benefits than are available through traditional fee-for-service medicare.

We believe the HMO option is sound and that it should be encouraged and expanded. I also want to discuss our recent experience with one HMO, IMC, which served medicare beneficiaries up until the first of this month when it became a part of Humana Medical Plan, Incorporated.

We believe private health plans like HMOs and CMPs should be a choice available to all medicare beneficiaries. These private health plans offer managed care that is designed to meet the full continuum of beneficiaries' medical needs. Private health plans provide, on average, $20 per month more in extra benefits or reduced out of pocket costs. These plans eliminate the need for beneficiaries to submit claims to medicare and medigap insurers, and that reduces dramatically the paperwork burden that they face. Private health plans enable providers to negotiate payment arrangements that they find fair based on local community standards. And finally, the use of private health plans serves medicare's need to operate more efficiently, thus preserving medicare's long-run financial viability. Strengthening private health plans is one of my agency's highest priorities and it's also high on Secretary Bowen's agenda. But I want to emphasize that our goal is to offer as many beneficiaries as possible a choice in the health care delivery system that meets their needs. They should always be free to choose for themselves, whether an HMO, competitive medical plan, or traditional fee-for-service medicare. It's not our desire and has never been our desire to force all or 80 percent or any other number of our beneficiaries into HMOs.

We implemented the medicare risk contracting authority enacted by the TEFRA legislation in April of 1985. Today, 16 million medicare beneficiaries live in areas where they have the option to join an HMO or CMP. Almost a million of them have chosen to enroll in one of 152 medicare contracts in 34 States. Our research shows that beneficiaries are satisfied with HMOs and that HMOs and CMPs can successfully do business with medicare. Our experience to date under the regulations implementing the TEFRA risk contracts has provided many valuable lessons. Some of these relate directly to IMC and some come from the whole of our experience. What I want to do today is to discuss briefly the specifics of the IMC situation and then discuss the lessons we have learned.

Since becoming HCFA Administrator in May, 1986, I have been concerned about the failure of IMC to meet the standards for Federal qualification as an HMO and the terms of its contract to serve medicare beneficiaries. Despite diligent work to correct deficiencies or seek a qualified buyer for IMC, we concluded on May 1 that the only recourse available to us was to terminate medicare's contract with IMC effective the end of July. Our response leaves no question in my mind about our ability to manage a termination of a plan, even the largest of the medicare plans. We took the following actions.

We immediately established toll free telephone numbers on which we have received more than 11,000 telephone inquiries from IMC enrollees. We set up task forces of HCVA staff in Miami and Tampa to resolve urgent medical problems. We sent a mailing to all IMC medicare members assuring them that Medicare coverage remained intact and apprising them of the situation and of their options. And we arranged for disenrollment, including access to medicare supplemental policies, without waiting periods or exclusions for pre-existing conditions.

Despite all of IMC's problems, beneficiaries continue to remain interested in the HMO option. Most beneficiaries who contacted us were anxious to remain in IMC or find another suitable HMO, if remaining in IMC became impossible. Since we announced the termination of their contract, the Florida Insurance Commissioner, Mr. Gunter, accepted the offer of Humana Medical Plan, Incorporated, to purchase certain assets of IMC effective June 1, and over 118,000 medicare enrollees were then transferred into Humana's plan.

We've learned a great deal from our TEFRA risk contracts and especially from our experience with IMC. In some cases, our lessons have led to our requests for legislation to strengthen our ability to enforce these contracts.

We believe that the most important lesson we've learned is the importance of the 50–50 standard, the requirement that only 50 percent of the plan can be made up of medicare or medicaid beneficiaries. We think it's an essential element to ensure quality.

We've only approved three waivers of that 50–50 standard. One of the plans is out of business, a second is currently reorganizing under Chapter 11 bankruptcy rules; and the third of those is IMC.

The second lesson that we've learned is that we have a need for sanctions other than termination of a plan from the program. Legislation enacted last year, which we supported, provided more options but did not go far enough. The Reagan administration is again this year proposing legislation that will authorize additional penalties such as suspended enrollment or civil monetary penalties for organizations that overcharge on their premiums, conduct improper enrollment, disenrollment or marketing practices.

We are also proposing to eliminate the options where medicare intermediaries pay for inpatient hospital and skilled nursing facilities services on behalf of the HMO and then we would deduct this payment from our payment to the HMO. We believe this is overly cumbersome and has led to a number of the problems we've had reconciling how much is owed IMC.

We believe that we should be allowed more flexibility to terminate a contract. Currently, HMO's have 90 days from the time we announce our intent to terminate before that termination takes effect. We believe in IMC's case that 90 days was too long and we plan to change our regulations to allow greater flexibility in the future. Although I did not support the Congress' desire that peer review organizations who review the quality of care in the fee-for-service sector also review the care rendered by private health plans such as HMOs, I want to assure you that we are working vigorously to implement this law. We are now signing contracts for quality review that will look at inpatient and outpatient care as of April 1, 1987, as is required. We believe too that amendments are necessary to that legislation having to do with allowing out-of-State physicians to review the care in HMOs, especially in States where there are not enough in-State HMO physicians. And, we believe also that we should be allowed to seek competitive bidding for agencies to do this review in all States. Our experience thus far with HMOs and CMPs has convinced us of the value of this option and it has taught us many lessons. Some of those I have already commented on. Many of these have already been enacted by the Congress; others await legislative action.

In addition, we continue our efforts to improve this private health plan option, for example, by researching ways to improve our payment method. And, we continue to believe that it's in the interests of patients and providers for medicare to delegate decisions about service delivery and price to reputable private firms. We're optimistic that this option will become increasingly available to medicare beneficiaries who do not now have such a choice. We believe the program is stronger than ever and we're proposing to expand further the range of private health plan options available to medicare beneficiaries.

Expanding the range of private health plans available builds on the TEFRA framework. We believe that framework to be sound. We further believe that strict adherence to the principles of that framework will assure that the plans available to our beneficiaries are sound, viable and provide quality health care services.

I'd be pleased to respond to your questions.

[The prepared statement of Dr. Roper follows:]

PREPARED STATEMENT OF WILLIAM R. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH & HUMAN SERVICES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I AM PLEASED TO HAVE THIS OPPORTUNITY TO DISCUSS MEDICARE'S PAST, PRESENT, AND FUTURE EXPERIENCE WITH HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS (HMOS AND CMPS). BENEFICIARIES WHO HAVE CHOSEN THIS OPTION ARE RECEIVING HIGH QUALITY CARE, MORE BENEFITS THAN THOSE AVAILABLE THROUGH TRADITIONAL FEE-FOR-SERVICE MEDICARE AND A COORDINATED CASE-MANAGED SYSTEM FOR DELIVERY OF CARE. FOR THESE REASONS WE BELIEVE THE HMO OPTION IS SOUND AND THAT IT SHOULD BE ENCOURAGED.

TODAY I WANT TO DISCUSS OUR EXPERIENCE, THE LESSONS WE HAVE DRAWN FROM THAT EXPERIENCE, AND OUR GOALS FOR THE FUTURE. I ALSO WANT TO DISCUSS OUR RECENT EXPERIENCE WITH ONE HMO OUT OF THE 152 HMOS AND CMPS WHO CURRENTLY CONTRACT WITH MEDICARE. THIS HMO IS INTERNATIONAL MEDICAL CENTERS (IMC), WHICH SERVED MEDICARE BENEFICIARIES UP TO JUNE 1 WHEN ITS MEDICARE PLAN BECAME PART OF HUMANA MEDICAL PLAN, INC.

WHY A PRIVATE HEALTH PLAN OPTION FOR MEDICARE BENEFICIARIES?

LET ME GIVE SOME OF THE REASONS WHY WE BELIEVE PRIVATE HEALTH PLANS LIKE HMOS AND CMPS SHOULD BE A CHOICE AVAILABLE TO MEDICARE BENEFICIARIES:

- O THESE PRIVATE HEALTH PLANS OFFER BENEFICIARIES MANAGED CARE, CARE THAT IS DESIGNED TO MEET THE FULL CONTINUUM OF MEDICAL NEEDS -- SOMETHING THE FRAGMENTED MEDICARE BENEFIT PACKAGE IS NOT DESIGNED TO DO. MANAGED CARE ALSO HAS THE POTENTIAL TO PROVIDE HIGHER QUALITY OF CARE BECAUSE IT CREATES A FOCAL POINT OF RESPONSIBILITY FOR AN INDIVIDUAL'S MEDICAL WELL-BEING.

- O THIS OPTION CAN PROVIDE MORE COVERAGE THAN FEE-FOR-SERVICE MEDICARE AND OFTEN REDUCE OUT-OF-POCKET COSTS. ON AVERAGE, MEDICARE'S HMO AND CMP CONTRACTORS PROVIDE THE MEDICARE

BENEFIT PACKAGE FOR $20 LESS PER MONTH THAN MEDICARE'S AVERAGE COST. PLANS RETURN SAVINGS TO BENEFICIARIES IN THE FORM OF LOWER COST-SHARING OR INCREASED BENEFITS. THESE BENEFITS, SUCH AS ROUTINE EYE CARE, PRESCRIPTION DRUGS, AND HEARING AIDS, ARE NOT COVERED BY TRADITIONAL MEDICARE.

37 HMOS DO NOT CHARGE MEDICARE BENEFICIARIES ANY PREMIUM FOR THE BASIC MEDICARE BENEFIT PACKAGE, A PHENOMENAL SAVING WHEN ONE CONSIDERS THAT THE AVERAGE OUT-OF-POCKET COST TO THE MEDICARE BENEFICIARY WHO RECEIVES CARE ON A FEE-FOR-SERVICE BASIS IS $38.00 PER MONTH. THIS FIGURE DOES NOT INCLUDE THE AMOUNTS PAID ABOVE THE MEDICARE ALLOWED CHARGE FOR PHYSICIAN SERVICES, SOMETHING HMO AND CMP MEMBERS DO NOT FACE.

- HMOS AND CMPS DO NOT REQUIRE THEIR ENROLLEES TO FILL OUT CLAIMS FORMS. AND THIS OPTION ELIMINATES THE NEED TO SUBMIT CLAIMS FORMS TO MEDICARE FIRST AND THEN TO A MEDIGAP INSURER.

- PRIVATE HEALTH PLANS ENABLE PROVIDERS TO NEGOTIATE PAYMENT ARRANGEMENTS THEY FIND FAIR BASED ON LOCAL COMMUNITY STANDARDS, RATHER THAN BE SUBJECTED TO THE UNIFORM RULES OF A CENTRALLY-ADMINISTERED MEDICARE PROGRAM. I'M SURE MANY OF YOU HAVE HEARD FROM CONSTITUENTS WHO COMPLAIN THAT NATIONAL MEDICARE REIMBURSEMENT PRINCIPLES DO NOT ADDRESS LOCAL CONDITIONS. DECENTRALIZATION OF PRICING AND DELIVERY DECISIONS WILL HELP TO CORRECT THESE PROBLEMS.

- FINALLY, THE USE OF PRIVATE HEALTH PLANS SERVES MEDICARE'S NEED TO OPERATE MORE EFFICIENTLY, SOMETHING NECESSARY TO PRESERVE MEDICARE'S LONG-RUN FINANCIAL VIABILITY.

HMOS AND CMPS ARE EXAMPLES OF PRIVATE HEALTH PLANS. STRENGTHENING THE PRIVATE HEALTH PLAN OPTION (PHPO) IS MY AGENCY'S HIGHEST PRIORITY AND IS ALSO HIGH ON SECRETARY BOWEN'S AGENDA. WHEN I SAY "STRENGTHEN," I DO NOT MEAN INCREASING ENROLLMENT. OUR GOAL IS TO INCREASE THE NUMBER, QUALITY AND AVAILABILITY OF BENEFICIARY CHOICES. WE WANT AS MANY BENEFICIARIES AS POSSIBLE TO HAVE THE CHOICE OF THE DELIVERY SYSTEM THAT BEST MEETS THEIR NEEDS -- BE IT AN HMO, CMP, OR FEE-FOR-SERVICE.

AMONG THE MEDICARE BENEFICIARIES TO WHOM THE HMO/CMP OPTION IS AVAILABLE, ONE IN FIFTEEN HAS CHOSEN TO RECEIVE THEIR HEALTH CARE THROUGH AN HMO OR CMP. OVER 900,000 MEDICARE BENEFICIARIES ARE NOW SERVED BY HMOS AND CMPS WHICH HOLD CONTRACTS UNDER RULES IMPLEMENTING THE RISK CONTRACTING PROVISIONS IN THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT (TEFRA). THEY ARE ENROLLED IN 152 PLANS LOCATED IN 34 STATES. AND MOST IMPORTANTLY, HMOS AND CMPS ARE NOW AVAILABLE AS AN OPTION FOR 16 MILLION BENEFICIARIES, FULLY ONE-HALF OF THE MEDICARE POPULATION. THIS LAST STATISTIC IS THE MOST IMPORTANT BECAUSE, AS I NOTED, OUR GOAL IS NOT TO INCREASE HMO ENROLLMENT BUT TO PROVIDE A CHOICE BETWEEN TRADITIONAL MEDICARE AND OTHER DELIVERY SYSTEMS, INCLUDING HMOS AND CMPS.

OUR EXPERIENCE TO DATE UNDER THE REGULATIONS IMPLEMENTING TEFRA HAS PROVIDED MANY VALUABLE LESSONS. THESE REGULATIONS, WHICH TOOK EFFECT ON APRIL 1, 1985, TRANSFORMED MEDICARE'S INVOLVEMENT WITH HMOS AND CMPS. IT PUT THE HMO PROGRAM ON A NEW FOOTING AND IMPLEMENTED OUR EXPERIENCE TO THAT POINT IN DEALING WITH HMOS. I WOULD LIKE TO DISCUSS THE SPECIFICS OF THE IMC SITUATION AND THEN DISCUSS THE LESSONS WE HAVE LEARNED THUS FAR ABOUT THE OPERATION OF TEFRA AND ITS IMPLEMENTING REGULATIONS.

TERMINATION OF INTERNATIONAL MEDICAL CENTERS' MEDICARE CONTRACT

IMC HAS TAKEN MORE OF MY TIME THAN ANY OTHER PROVIDER SINCE I BECAME HCFA ADMINISTRATOR A YEAR AGO.

SHORTLY AFTER COMING TO THE AGENCY, I REVIEWED THE FACTS SURROUNDING IMC AND I INFORMED IMC THAT THEY WERE OUT OF COMPLIANCE WITH THE STANDARDS FOR FEDERAL QUALIFICATION AS AN HMO, A PREREQUISITE FOR IMC'S HOLDING A CONTRACT TO SERVE MEDICARE BENEFICIARIES. I REQUESTED A CORRECTIVE ACTION PLAN. SINCE RECEIPT OF THAT PLAN ON JUNE 27, 1986, HCFA STAFF MADE 36 SITE VISITS TO OVERSEE IMPLEMENTATION OF THE CORRECTIVE ACTION PLAN.

IN ADDITION, IMC HAD SERIOUS PROBLEMS RELATING TO THE 50/50 STANDARD REQUIRED OF MEDICARE'S HMO AND CMP CONTRACTORS. UNDER TEFRA RULES, AN HMO OR CMP MAY NOT HAVE MORE THAN HALF OF ITS ENROLLEES BE MEDICARE AND MEDICAID ELIGIBLES -- THUS THE NAME,

"50/50". IMC BEGAN ITS RELATIONSHIP WITH MEDICARE AS A DEMONSTRATION PROJECT IN 1982. THE TERMS OF THAT DEMONSTRATION ALLOWED FOR UP TO 75% OF IMC'S TOTAL ENROLLMENT TO COME FROM MEDICARE AND MEDICAID. THE TEFRA REGULATIONS ALLOWED A TRANSITION PERIOD OF UP TO THREE YEARS FOR HMOS AND CMPS WHICH BEGAN AS MEDICARE DEMONSTRATION PROJECTS AND WHICH DID NOT MEET THE 50/50 STANDARD. IMC SIGNED A TEFRA CONTRACT IN APRIL 1985, AND RECEIVED THE WAIVER OF 50/50 ALLOWED UNDER THE TEFRA RULES. ONLY TWO OTHER DEMONSTRATION PROJECTS REQUESTED SUCH A WAIVER, AND ONLY ONE OF THESE IS STILL IN OPERATION.

ON JULY 18TH OF LAST YEAR, HUMANA INDICATED ITS INTENT TO ACQUIRE IMC. BASED ON CONTINUED REASSURANCES BY BOTH HUMANA AND IMC THAT NEGOTIATIONS WERE IN PROGRESS, WE HELD OUT HOPE THAT THEIR TRANSACTION WOULD PUT IMC ON A FIRM FOOTING TOWARDS MEETING THE TERMS OF THE CORRECTIVE ACTION PLAN AND THE 50/50 STANDARD. AS THESE NEGOTIATIONS BECAME MORE PROLONGED, IT BECAME APPARENT THAT THIS ACQUISITION WAS NOT GOING TO TAKE PLACE. FINALLY, IN MARCH OF THIS YEAR, I ASKED HCFA'S OFFICE OF PREPAID HEALTH CARE TO CONDUCT A FINAL REVIEW OF IMC TO DETERMINE EXACTLY WHERE ITS OPERATIONS STOOD. THAT REVIEW INDICATED THAT ALTHOUGH PROGRESS HAD BEEN MADE TO CARRY OUT THE CORRECTIVE ACTION PLAN, PARTICULARLY IN REGARD TO THE QUALITY OF CARE, IMC STILL FELL SHORT OF THE STANDARDS NECESSARY FOR A MEDICARE CONTRACT. IN PARTICULAR, THERE WAS NO PROGRESS TOWARD MEETING 50/50 BALANCE BETWEEN COMMERCIAL ENROLLEES AND MEDICARE/MEDICAID BENEFICIARIES. FROM JUNE 1986 THROUGH APRIL 1987, THE MEDICARE SHARE OF IMC'S ENROLLMENT GREW FROM 71% TO 78%.

135,000 MEDICARE BENEFICIARIES VOLUNTARILY ELECTED IMC. WE DID NOT WISH TO DENY THESE PEOPLE THEIR CHOICE UNTIL WE HAD PURSUED EVERY POSSIBLE SOLUTION SHORT OF TERMINATION. IN THE END, IMC LEFT US NO CHOICE. I NOTIFIED IMC ON MAY 1, 1987, THAT ITS MEDICARE CONTRACT WAS TERMINATED EFFECTIVE JULY 31, 1987.

AS YOU CAN IMAGINE, THE LAST MONTH HAS BEEN VERY HECTIC. OUR RESPONSE TO THE SITUATION WAS VIGOROUS. WE ASKED HCFA STAFF TO PERFORM TO THEIR UTMOST. I WOULD BE REMISS IF I DID NOT PRAISE THE DEDICATION AND SERVICE ABOVE THE CALL OF DUTY SHOWN BY MY AGENCY'S STAFF, ESPECIALLY THE STAFF IN OUR OFFICE OF PREPAID HEALTH CARE. THEIR WORK WAS A TRIBUTE TO THE IDEAL OF PUBLIC SERVICE.

UPON MAKING THE TERMINATION ANNOUNCEMENT:

- WE IMMEDIATELY ESTABLISHED TOLL-FREE TELEPHONE NUMBERS FOR MEDICARE BENEFICIARIES ENROLLED IN IMC TO CALL FOR INFORMATION OR REPORT PROBLEMS IN OBTAINING CARE. FOR THE FOLLOWING THREE WEEKS WE STAFFED OUR TELEPHONE BANK FOR 12 HOURS A DAY, SEVEN DAYS A WEEK. SINCE THE LAST WEEK OF MAY THE LINES HAVE BEEN STAFFED FIVE DAYS A WEEK FOR TEN HOURS PER DAY. AS OF MAY 28, 11,500 TELEPHONE INQUIRIES WERE RECEIVED;

- WE SET UP TASK FORCES OF HCFA STAFF IN MIAMI AND TAMPA. THESE GROUPS RESOLVED URGENT PROBLEMS -- FOR EXAMPLE, THOSE INVOLVING INABILITY TO OBTAIN CARE. RECORDS OF THE INQUIRES HANDLED BY THIS STAFF WILL BE REFERRED TO THE OFFICE OF INSPECTOR GENERAL FOR FURTHER INVESTIGATION;

- WE SENT A MAILING TO ALL IMC MEDICARE MEMBERS APPRISING THEM OF THE SITUATION AND OF THEIR OPTIONS; AND,

- WE ARRANGED FOR EASY ACCESS TO MEDICARE SUPPLEMENTAL POLICIES WITHOUT WAITING PERIODS OR EXCLUSION FOR PRE-EXISTING CONDITIONS FOR THOSE WHO WANTED TO DISENROLL.

OUR RESPONSE LEAVES NO QUESTION IN MY MIND ABOUT OUR ABILITY TO MANAGE A PLAN TERMINATION. WE ALSO LEARNED THAT MOST BENEFICIARIES WHO CONTACTED US WERE ANXIOUS TO REMAIN WITH IMC OR FIND ANOTHER HMO IF REMAINING WITH IMC BECAME IMPOSSIBLE.

SINCE WE ANNOUNCED THE TERMINATION OF IMC'S CONTRACT, THE SITUATION HAS CHANGED FOR THE BETTER. ON MAY 14, A FLORIDA STATE COURT DECLARED IMC INSOLVENT AT THE REQUEST OF THE FLORIDA STATE INSURANCE COMMISSIONER. AS A RESULT OF THE INSOLVENCY PROCEEDINGS, THE INSURANCE COMMISSIONER ACCEPTED THE OFFER OF HUMANA MEDICAL PLAN, INC. TO PURCHASE CERTAIN ASSETS OF IMC, INCLUDING ITS GOLD PLUS MEDICARE PLAN, AND THE INSOLVENCY COURT APPROVED THE SALE.

HUMANA MEDICAL PLAN, INC. HAS SIGNED A CONTRACT TO SERVE MEDICARE BENEFICIARIES. MEDICARE BENEFICIARIES ENROLLED IN THE IMC GOLD PLUS PLAN WERE AUTOMATICALLY TRANSFERRED TO THE HUMANA PLAN

EFFECTIVE MONDAY, JUNE 1. WE HOPE IMC'S SUCCESSOR, BACKED BY A REPUTABLE, WELL-CAPITALIZED FIRM WITH EXTENSIVE EXPERIENCE IN DELIVERING HEALTH CARE, WILL PROVIDE WHAT IS NEEDED TO MAKE THE ORGANIZATION A VIABLE, THRIVING HMO.

IN HINDSIGHT, OUR CONTRACT WITH IMC COULD HAVE BEEN BETTER MANAGED. WE HAVE LEARNED A GREAT DEAL FROM OUR EXPERIENCE AND MISTAKES WITH IMC. OUR LESSONS HAVE LED TO OUR REQUEST FOR LEGISLATION TO STRENGTHEN OUR ABILITY TO ENFORCE OUR CONTRACTS WITH HMOS AND CMPS. SOME TOOLS WERE INCLUDED IN THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT AND THE OMNIBUS BUDGET RECONCILIATION ACT. WE ARE ALSO PROPOSING NEW LEGISLATION WHICH SECRETARY BOWEN PLANS TO FORWARD SOON THAT WILL PROVIDE IMPORTANT ADDITIONAL TOOLS TO MANAGE OUR RISK CONTRACTORS. MOST OF OUR LESSONS FROM MAKING TEFRA WORK ARE REFLECTED IN THIS LEGISLATION.

OUR LESSONS TO DATE

o THE IMPORTANCE OF THE 50/50 STANDARD. AS I NOTED, VIABILITY IN THE COMMERCIAL MARKETPLACE IS, AND SHOULD BE, A PREREQUISITE FOR SERVING MEDICARE BENEFICIARIES. WE BELIEVE 50/50 IS AN ESSENTIAL ELEMENT OF OUR QUALITY ASSURANCE EFFORT, ALTHOUGH IT IS NOT, BY ITSELF, A SUFFICIENT GUARANTY. THE 50/50 STANDARD ASSURES MEDICARE BENEFICIARIES THAT THEY ARE ENROLLED IN A DELIVERY SYSTEM WHICH HAS BEEN SUCCESSFUL IN ATTRACTING NON-MEDICARE/MEDICAID MEMBERS. THESE COMMERCIAL MEMBERS HAVE EMPLOYERS AND UNIONS WHICH ACT AS PURCHASING AGENTS FOR THEM. MANY GROUP PURCHASERS, THOUGH NOT ALL, ARE SOPHISTICATED PURCHASERS WHO ARE PRICE AND QUALITY CONSCIOUS. BY REQUIRING THAT THE 50/50 STANDARD BE MET IN EACH AREA SERVED BY AN HMO, AND THAT MEDICARE BENEFICIARIES BE SERVED BY A DELIVERY SYSTEM WHICH IS SUBSTANTIALLY SIMILAR TO THAT SERVING COMMERCIAL MEMBERS, WE CAN ASSURE THAT THE INTERESTS OF MEDICARE BENEFICIARIES ARE PROTECTED.

IMC'S MEMBERSHIP IMBALANCE ULTIMATELY DISRUPTED ITS SENSE OF PRIORITIES. IT BECAME MEDICARE DEPENDENT, UNABLE TO EXIST WITHOUT ITS MEDICARE CONTRACT. IT BEGAN TO PERCEIVE ITS MISSION AS LOBBYING TO PRESERVE ITS MEDICARE CONTRACT, NOT REMEDYING THE PROBLEMS WHICH THREATENED ITS CONTRACT.

o THE NEED FOR OTHER SANCTIONS. THE ONLY ALTERNATIVE TO

ALLOWING IMC TO OPERATE AS IT DID WAS TERMINATION. THE DISRUPTION THAT MEDICARE BENEFICIARIES WOULD EXPERIENCE DICTATED THAT TERMINATION ONLY BE CONSIDERED IN THE MOST SERIOUS OF CIRCUMSTANCES. TERMINATION MEANT, AMONG OTHER THINGS, THAT BENEFICIARIES WOULD LOSE THE ADDITIONAL BENEFITS IMC PROVIDED AT NO CHARGE AND THAT THEY WOULD HAVE TO FIND NEW PROVIDERS OF HEALTH CARE SERVICES.

LEGISLATION WE HAVE SUPPORTED HAS ALREADY STRENGTHENED OUR HAND. THE OMNIBUS BUDGET RECONCILIATION ACT OF 1986 ALLOWS THE SECRETARY TO SUSPEND NEW ENROLLMENT IN PLANS WHICH VIOLATE THE 50/50 STANDARD. ADDITIONALLY, THAT STATUTE PROVIDES A USEFUL TOOL TO DEAL WITH HMOS WHICH ARE LATE IN PAYING THEIR BILLS. IT CREATED THE AUTHORITY FOR HCFA, WHERE APPROPRIATE, TO PAY UNAFFILIATED PROVIDERS DIRECTLY AND DEDUCT THE AMOUNT FROM MEDICARE'S PAYMENT TO THE HMO.

WE BELIEVE THE ADDITIONAL AUTHORITY THAT WE ARE PROPOSING WILL ALSO ENHANCE OUR ABILITY TO MANAGE HMOS WITH MEDICARE RISK CONTRACTS. OUR PROPOSALS WOULD MAKE IT POSSIBLE TO SUSPEND ENROLLMENT OR IMPOSE CIVIL MONEY PENALTIES ON ORGANIZATIONS THAT:

- OVERCHARGE ON PREMIUMS,
- IMPROPERLY FAIL TO ENROLL, OR IMPROPERLY DISENROLL, INDIVIDUALS,
- ENGAGE IN ANY PRACTICE TO DENY OR DISCOURAGE ENROLLMENT BY INDIVIDUALS WITH A NEED FOR SUBSTANTIAL MEDICAL SERVICES, OR
- MISREPRESENT OR FALSIFY INFORMATION.

WE HAVE BEEN TROUBLED BY THE ALLEGATIONS OF MARKETING ABUSES INVOLVING SEVERAL SOUTH FLORIDA HMOS. MANY OF IMC'S PROBLEMS STEMMED FROM ITS RAPID RATE OF GROWTH. ITS MEDICARE ENROLLMENT WENT FROM APPROXIMATELY 5,000 AT THE END OF 1981 TO 135,000 AT THE TIME THE MEDICARE CAP WAS SET IN JUNE, 1986. THE TEFRA RULES ALLOW HMOS SERVING MEDICARE BENEFICIARIES TO TAKE ONE OF THREE APPROACHES TO ENROLLMENT. THE HMO MAY HAVE AN ENROLLMENT PERIOD OF A SPECIFIED LENGTH OF TIME, IT MAY ENROLL MEMBERS UP TO A PRE-SET LIMIT, OR IT MAY ENGAGE IN CONTINUOUS OPEN ENROLLMENT. IMC CHOSE THE LAST OPTION. IMC'S MEMBERSHIP DID NOT GROW ACCORDING TO A WELL-DEVELOPED MANAGEMENT STRATEGY, BUT RATHER ACCORDING TO THE MOMENT-TO-MOMENT SUCCESSES OF ITS MARKETING EFFORT.

o ELIMINATION OF THE OPTION WHEREBY MEDICARE'S FISCAL INTERMEDIARIES MAKE PAYMENTS FOR AN HMO. UNDER CURRENT LAW AN HMO OR CMP MAY OPT TO HAVE MEDICARE PAY FOR INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES AND THEN DEDUCT THE PAYMENT FROM THE MEDICARE PAYMENT TO THE HMO. WE ARE PROPOSING TO ELIMINATE THIS OPTION. IMC'S USE OF THIS OPTION LED TO MEDICARE OVERPAYMENTS. THE PROBLEMS ASSOCIATED WITH THIS OPTION HAVE GROWN AS THE NUMBER OF BENEFICIARIES ENROLLED IN HMOS HAS GROWN, CONVINCING US THAT THIS ARRANGEMENT IS UNSUITABLE FOR A LARGE, MATURE PRIVATE HEALTH PLAN PROGRAM. WE BELIEVE THAT INTERMEDIARY PAYMENTS ON BEHALF OF RISK HMOS ARE GENERALLY UNNECESSARY AND ARE AN ADMINISTRATIVE BURDEN TO HCFA, INTERMEDIARIES AND HMOS.

o ALLOW MORE FLEXIBILITY TO TERMINATE A CONTRACT. CURRENT REGULATIONS REQUIRE THAT AN HMO HAVE 90 DAYS FROM THE TIME WE ANNOUNCE OUR INTENT TO TERMINATE BEFORE THE TERMINATION TAKES EFFECT. THE IMC SITUATION HAS SHOWN THAT AMOUNT OF TIME IS TOO LONG IN SOME CASES. THEREFORE WE PLAN TO CHANGE OUR REGULATIONS TO ALLOW MORE FLEXIBILITY WHEN TERMINATION IS NECESSARY. FOR EXAMPLE, WHEN OUR INSPECTIONS REVEAL SERIOUS QUALITY PROBLEMS, A SHORTER TERMINATION PERIOD WOULD BE WISE.

o REVIEW BY INDEPENDENT ENTITIES WILL HELP ASSURE THE QUALITY OF CARE RENDERED BY HMOS AND CMPS. WHILE I WAS NOT MYSELF CONVINCED THAT EXTERNAL REVIEW OF THE TYPE USED TO REVIEW CARE IN THE FEE-FOR-SERVICE SECTOR WAS APPROPRIATE FOR PRIVATE HEALTH PLANS, THE CONGRESS DECIDED OTHERWISE, AND I RESPECT THAT DECISION. I AND MY STAFF ARE WORKING VIGOROUSLY TO IMPLEMENT THE CONGRESS' DESIRE THAT PEER REVIEW ORGANIZATIONS (PROS) REVIEW THE QUALITY OF CARE RENDERED BY PRIVATE HEALTH PLANS.

WE ARE SIGNING CONTRACTS WITH ORGANIZATIONS WHICH WILL CONDUCT REVIEW. IN HALF THE STATES, THE CONTRACTS ARE WITH THE PROS WHICH ALREADY REVIEW THE CARE PROVIDED BY THE FEE-FOR-SERVICE SECTOR. IN THE OTHER HALF, CONTRACTS HAVE BEEN COMPETITIVELY BID, ALLOWING NON-PROS TO BID. WE CALL THESE ORGANIZATIONS "QUALITY REVIEW ORGANIZATIONS" OR QROS. THE LAW REQUIRED THAT THIS REVIEW BEGIN BY APRIL 1. TIME DID NOT ALLOW FOR ALL THE STEPS IN THE CONTRACTING PROCESS TO BE COMPLETED BY THAT DATE. HOWEVER, THE CONTRACTS ARE FOR SERVICES PROVIDED AFTER APRIL 1.

TO BECOME A FEDERALLY QUALIFIED HMO, A PREREQUISITE FOR SIGNING A CONTRACT WITH MEDICARE, AN ORGANIZATION MUST HAVE A QUALITY ASSURANCE PLAN. AS A PRACTICAL MATTER, THESE PLANS ARE ONLY AS VALUABLE AS THE HMO MANAGEMENT'S COMMITMENT TO MAKING THEM WORK. WE BELIEVE THE KNOWLEDGE THAT FOR THE FIRST TIME SOMEONE WILL EXAMINE THE OUTCOME OF THOSE INTERNAL PLANS WILL ITSELF INCREASE ATTENTIVENESS TO QUALITY ASSURANCE.

AS WE HAVE LOOKED AT HOW TO MONITOR QUALITY THROUGHOUT THE MEDICARE AND MEDICAID PROGRAMS, WE HAVE SEEN THE IMPORTANCE OF FOCUSING ON OUTCOMES AS A MEASURE. OUR PLAN FOR REVIEWING QUALITY IN HMOS IS CONSISTENT WITH THIS OBSERVATION. REVIEW WILL BE AT EITHER THE "LIMITED," "BASIC" OR "INTENSIFIED" LEVELS. AN HMO OR CMP'S PERFORMANCE WILL DETERMINE WHICH LEVEL OF REVIEW IT RECEIVES. EVEN THOSE HMOS QUALIFYING FOR LIMITED REVIEW WILL HAVE SOME CASES REVIEWED BY THE PRO OR QRO. MOREOVER, THE PRO/QRO WILL SAMPLE CASES REVIEWED BY THE HMO'S INTERNAL QUALITY ASSURANCE SYSTEM TO ASSURE THAT SYSTEM IS FUNCTIONING PROPERLY.

WE HAVE FOUND OUR EFFORT TO OBTAIN THE BEST POSSIBLE REVIEW HAMPERED BY THE CURRENT LAW REQUIREMENT THAT ORGANIZATIONS WHICH REVIEW HMOS MEET THE REQUIREMENTS FOR PEER REVIEW ORGANIZATIONS WHICH REVIEW CARE PROVIDED IN THE FEE-FOR-SERVICE SECTOR. WE BELIEVE THAT THE REQUIREMENT THAT ONLY IN-STATE PHYSICIANS BE USED MAY CREATE A CONFLICT OF INTEREST IN STATES WHERE THE HMO/CMP OPTION IS NEW OR WHERE THE POOL OF PHYSICIANS WORKING IN THE HMO/CMP ENVIRONMENT IS SMALL. WE ALSO BELIEVE THAT PHYSICIANS REVIEWING CARE IN HMOS AND CMPS SHOULD THEMSELVES WORK IN THIS ENVIRONMENT. WE HAVE PROPOSED ALLEVIATING THIS SITUATION BY ELIMINATING THE REQUIREMENT THAT PHYSICIANS REVIEWING CARE PROVIDED BY HMOS BE FROM THE STATE WHERE THE HMO IS LOCATED. WE ALSO BELIEVE FUTURE CONTRACT SOLICITATIONS SHOULD BE COMPETITIVELY BID AND OPEN TO ALL QUALIFIED BIDDERS IN ALL STATES.

OUR EXPERIENCE THUS FAR WITH HMOS AND CMPS HAS CONVINCED US OF THE VALUE OF THIS OPTION AND IT HAS TAUGHT US MANY LESSONS, SOME OF WHICH WE HAVE ALREADY ACTED UPON, AND OTHERS WHICH AWAIT LEGISLATIVE ACTION.

WE CONTINUE OUR EFFORTS TO GRAPPLE WITH THE CHALLENGES POSED BY

THE GROWING POPULARITY OF THE PRIVATE HEALTH PLAN OPTION. THE PAYMENT METHOD FOR PRIVATE HEALTH PLANS, CENTERING ON THE ADJUSTED AVERAGE PER CAPITA COST (AAPCC), HAS BEEN RIGHTLY CRITICIZED FOR NOT TAKING INTO ACCOUNT ALL THE FACTORS THAT SHOULD DETERMINE A FAIR PAYMENT RATE. OUR RESEARCH PROGRAM IS TRYING TO FIND BETTER WAYS TO DETERMINE A PAYMENT RATE. WE ARE ALSO CONCERNED ABOUT THE FINANCIAL INCENTIVES USED WITHIN HMOS. WE ARE GATHERING DATA TO FULFILL A MANDATE TO REPORT TO CONGRESS BY THE END OF THE YEAR ON THE APPROPRIATENESS OF THESE FINANCIAL ARRANGEMENTS.

OVERALL, THE PROGRAM IS NOW STRONGER THAN EVER. WE CONTINUE TO BELIEVE THAT IT IS IN THE INTERESTS OF PATIENTS AND PROVIDERS FOR MEDICARE TO DELEGATE DECISIONS ABOUT SERVICE DELIVERY AND PRICE TO REPUTABLE PRIVATE FIRMS. THE NEW REVIEW OF QUALITY OF CARE PROVIDED BY HMOS AND LAST YEAR'S PENALTY PROVISION PROVIDE US WITH MORE TOOLS TO USE AGAINST PROBLEM HMOS.
WE HAVE MORE EXPERIENCE IN KNOWING HOW TO MANAGE THE PROGRAM AND HOW TO RECOGNIZE WHEN AN HMO IS NOT PROVIDING QUALITY CARE.
WE ARE OPTIMISTIC THAT THE HMO AND CMP OPTION WILL BECOME INCREASINGLY AVAILABLE TO MEDICARE BENEFICIARIES WHO DO NOT NOW HAVE A CHOICE. WE PLAN TO SEND THE CONGRESS LEGISLATION TO EXPAND FURTHER THE RANGE OF PRIVATE HEALTH PLAN OPTIONS AVAILABLE TO MEDICARE BENEFICIARIES. WE WANT TO EXPAND THE PRIVATE HEALTH PLAN OPTION TO EMPLOYMENT-BASED PLANS. EXPANDING THE RANGE OF PRIVATE HEALTH PLANS AVAILABLE TO MEDICARE BENEFICIARIES BUILDS ON THE TEFRA FRAMEWORK WHICH HAS PROVEN TO BE SOUND. OUR LESSON FOR FUTURE ADMINISTRATORS OF THE MEDICARE PROGRAM IS THAT STRICT ADHERENCE TO THE PRINCIPLES OF THAT FRAMEWORK WILL ASSURE THAT THE PLANS AVAILABLE TO BENEFICIARIES ARE SOUND, VIABLE, AND PROVIDE QUALITY HEALTH CARE.

I WILL BE PLEASED TO ANSWER ANY QUESTIONS YOU MAY HAVE.

The CHAIRMAN. Thank you, Dr. Roper. You probably remember that the first question that I asked Mr. Mica was the following. Do Federal and State authorities move aggressively enough to enforce the medicare demonstration of risk contracts?

I'd like to ask you the same question, in view of the fact that on page 9 of your statement, you say our lessons have led us to request legislation to strengthen our ability to enforce our contracts with HMOs.

Now, what is the answer to that question? Do Federal and State authorities move aggressively enough to enforce medicare demonstration and risk contracts?

Dr. ROPER. Your question is did we move aggressively enough in the past?

The CHAIRMAN. Do you generally move? I'm talking about both the Federal Government and, in your opinion, the States.

Dr. ROPER. It's my conviction, Mr. Chairman, that we are moving aggressively enough at the present time. I don't think we were aggressive enough in the past. One of the problems is until recently, we had only the option to terminate a plan, to execute them, if you will. That was the only available tool other than jawboning. Now, we have been given some intermediate sanctions through the OBRA legislation of last year. We seek additional intermediate sanctions to get the message across to a plan that they have to do things to come into compliance with our regulations. The intermediate steps, I think, will be important in assuring that we don't have future IMCs.

The plan, IMC, as has been said earlier, was the largest medicare HMO. Despite the problems that it had, we continue to hear that large numbers of the enrollees were quite pleased with the care that they were getting. And so my predecessors and I were reticent to execute them, cut them from the program altogether. But finally, I came to believe that that was the choice that we had to make and so we moved aggressively to terminate IMC from the program. We've done that.

The CHAIRMAN. Dr. Roper, I agree with what you're saying. I think that you as an individual have in fact moved aggressively. You've been in your present position for 1 year. The truth of the matter is that in 1984 the Committee on Aging highlighted the problems of IMC and we did that for the administration and for the Florida Insurance Commissioner and still it has taken 3 or 4 years to get the problems resolved. And had you not come in a year ago, I think we still would be in the same boat. I'd like to compliment you for the work you've done in the last year.

Now, I'm going to assume the role of most of my constituents. What have you done for us lately?

Dr. ROPER. I think the biggest thing we've done is terminated IMC from the program. That has, I think, given a message to the entire health care community, especially the HMO community, that we are not going to tolerate bad apples and our compliance officials tell me that they have noticed a difference in the response that they are getting to their inquiries and their recommendations, if you will. People take our actions more seriously today than they did a couple of months ago.

The CHAIRMAN. Do you have oversight capabilities? Can you go into let's say my State and look over one of the HMOs that I have in mind at the moment?

Dr. ROPER. Yes, sir. We do have that capability and we are doing that.

The CHAIRMAN. So then it's your intention to really move in an aggressive manner in correcting the situation no matter where it is in the United States?

Dr. ROPER. Yes, sir. Indeed.

The CHAIRMAN. I was interested also in the legislation that you say that you have recommended to the committee. Can you very briefly describe that?

Dr. ROPER. Sure. There are a number of provisions in this bill. It is surely going to be brought forward to the Congress. It's called the Medicare Expanded Choice Act. The provisions that I dwelt on in particular would give us sanction authority to deal with problems of enrollment and disenrollment practices, certain marketing abuses that a plan might be guilty of, giving us the ability to levy civil monetary penalties and take other sanctions against a plan that is operating outside the law, outside the regulations.

The CHAIRMAN. Thank you. Mr. Mica.

Mr. MICA. Thank you, sir. In describing the Mica legislation, by which we were pleased that we were able to take the lead in some of this, I guess my question goes back to, maybe predates your time. Where was HCFA? You know, I can tell you, and I'm not an expert, but I worked with an expert in health care for a little while. I know enough about HMOs to know that if you have 100 to 200,000 members, 70, 80, 90 percent will probably always be satisfied because they go in, they get an aspirin, they get a bandaid and they love it. The Federal Government pays $100 a month for that.

But what we are talking about is where people needed surgery, they needed hospitalization. Our review of the record shows that IMC heavily underutilized hospitals. One of the complaints was that oftentimes people were dying and they needed specialist care and they were given just medication. So what I would say to your answer that we have checked and a lot of people were happy, is that I hope the Federal Government can devise a method to find out not only who is happy but the type of care they get.

I talked to one person who called me up and said I love HMOs, I love IMC. I said well, have you utilized it? He said no, I never have. Well, he was happy. He had never used them. And I talked to many people when they got to that problem of needing surgery, and that's where it all came together and got stuck.

Dr. ROPER. Your point is well made. But, just for the record, I want to make sure everybody understands as you do that all of the complaints we got from all sources, including from Members of Congress, have been sent to the Office of the Inspector General. They are pursuing a number of investigations about specific complaints and there well may be forthcoming action in regard to those. We're putting in place a very detailed——

Mr. MICA. I have not addressed this because we're one congressional office with a very limited staff. We have been working on this. We don't have an answer. You have an entire, I don't want to say bureaucracy, an entire army of technical, well-trained people.

What do you propose to do about underutilization in HMOs where they just really want to give them bandaids and medication? There's been at least one and maybe two Federal studies that indicate that there is a tendency in HMOs to overmedicate and underoperate. We don't want to go the other way: under other systems we have an overemphasis on operations and surgical procedures. How are we going to balance that?

Dr. ROPER. We're doing several things.

First, to go back to the question of complaints, we are putting in place a detailed system that will track any and every complaint that we get and fully investigate that complaint so that we are aware of specific complaints and also aware of any patterns that might emerge.

As to the general question of what you do about undertreatment, people not getting access to needed care, however you want to put it, that is both a theoretical and a practical concern about the way HMOs are arranged.

It's because of that that we are putting in place now the oversight of the quality of care in HMOs using the peer review organizations and quality review organizations.

The specific methodology that those review organizations will use will look at patients who were out-patients and who never made it to hospitals. For example, people who had high blood pressure and that were not adequately looked after, or people with diabetes who did not have early intervention and good control of their diabetes. The quality review mechanism is designed to make sure that we look for the possibility of undertreatment. But let me just end by saying while undertreatment is a very real consideration, a concern that we want to pay attention to, I don't think it should be viewed as an indictment of prepaid health plans in general. Otherwise——

Mr. MICA. I agree with that.

Dr. ROPER. I heard your earlier statement, but let me just add, for up until now, the whole health care system has been oriented toward doctors and hospitals having incentives to do more for patients. Now, in prepaid plans, they have an incentive to do less. And we need to balance that out so it's done——

Mr. MICA. Specifically with regard to actions of the past, is there an internal investigation, is the Inspector General's office looking at why HCFA didn't move earlier on an investigation into the individuals who went from HCFA to work for this company?

Dr. ROPER. Those individuals are being investigated. We've done a thorough investigation——

Mr. MICA. Have you ever had political pressure leveled at you not to become involved, or to lay off?

Dr. ROPER. No.

Mr. MICA. Do you have, I don't know what the estimate is, $40, $50, $80, $100 million in creditors out there—have you and Mr. Gunter worked out a plan to see that those people are paid? Whose responsibility is it?

Dr. ROPER. We're working very closely with the Insurance Commissioner's office, and have very good cooperation right now. How the creditors, how many creditors there are, the total amount that's owed to them, I don't know right now.

Mr. MICA. What's the latest estimate?

Dr. ROPER. It's many millions of dollars. He can give you the latest answer. We are anxious that especially claims owed to beneficiaries are handled as quickly as possible. The potential source of funds to satisfy those claims is the money that Humana paid for IMC and the insolvency insurance that IMC had.

Mr. MICA. I know I'm pressing the committee's time. One quick point, on Humana. They bought it out. IMC is not in compliance with the 50–50 rule. What are you going to do a year from now or 2 years from now or 6 months from now to bring IMC into compliance?

Dr. ROPER. We've given them a series of milestones that we expect them to meet and they're to come back to us by September 1st with a detailed plan on how they're going to enroll nonmedicare people to get the numbers down.

Mr. MICA. Can I get a copy of that?

Dr. ROPER. Sure.

[The following material was subsequently received from Mr. Roper.]

Contract Requirment with Humana to Meet
Medicare Enrollment Standard

1. Exception to Composition of Enrollment Standard

On the basis of the conditions specified in 42 CFR 417.413(e) and Section 9312(c)(3)(C) of the Omnibus Budget Reconciliation Act (OBRA) of 1986 (P.L. 99-509), an exception to the composition of enrollment standards is granted to Humana Medical Plan, Inc.

Humana Medical Plan, Inc., agrees, per the provisions of Section 9312(c)(3)(C) of OBRA to make reasonable efforts to meet scheduled enrollment goals consistent with a schedule of compliance approved by the Secretary. Humana Medical Plan, Inc., agrees to submit a schedule of compliance to the Health Care Financing Administration (HCFA) for review by September 1, 1987. Such schedule shall project both Medicare and commercial enrollment, on a monthly basis, through one year beyond the date on which compliance with the 50 percent requirement is projected to be met. The schedule shall be accompanied by a detailed market analysis which supports the enrollment projections.

The current exception to the enrollment standard applies through March 31, 1988. At that time, if enrollment of Medicare and Medicaid members is less than 70 percent of total membership, a one-year extension will be granted to March 31, 1989. If enrollment of Medicare and Medicaid members is less than 60 percent of total membership on March 31, 1989, a further one year extension will be granted.

2. Medicare/Medicaid Enrollment Cap

Humana Medical Plan, Inc., agrees that during the period of the exception (refer to paragraph 1), Medicare/Medicaid enrollment may not exceed 130,000.

3. Benefits and Premiums

Humana Medical Plan, Inc., agrees to publicly offer and provide throughout the first seven months of the contract the benefit package contained in HCFA's December 31, 1986 notice of approval of the ACR submitted by International Medical Centers, Inc. (attached hereto)

4. Marketing Materials

Humana Medical Plan, Inc., agrees to submit any marketing materials to HCFA for review at least 45 days before their planned distribution.

5. Health Services Delivery System

Humana Medical Plan, Inc., agrees to make any necessary changes to the health services delivery system to assure that the full range of services for which Medicare members have contracted are available, accessible, and furnished in a manner that ensures continuity and quality of care.

The CHAIRMAN. Thank you. We are now under the 5 minute rule. The committee now recognizes the gentleman from Florida, Mr. Pepper.

Mr. PEPPER. Thank you very much, Mr. Chairman.

I wish to commend you for having this hearing because I think it's very much in the public interest. I'm sorry I haven't been able to attend all of it, and I'm afraid I've got to go back over to the Capitol after I make a brief statement.

Dr. Roper, I want to commend you for what I think has been your fairness in dealing with the problems in our State, with which I am familiar. I think you've tried to be fair to everybody involved, the public as well as the private sector people. I have heard you say before and I hope you repeat it at this hearing, that the unhappy experience we've had with some HMOs does not cause you to oppose the concept of the HMO. I strongly favor that concept. I've fought for every HMO to get an opportunity to participate in the program. Some of them have disappointed me. On the whole, the HMOs have rendered more medical care to the elderly than they would have received otherwise, according to my information. So the fact that some have failed in living up to their obligation does not cause me to decry the whole system of HMOs. I have a relative who had a serious illness, was in the hospital, belonged to an HMO in Florida, and the bill was $13,000. These are just middle-income people. The HMO paid the whole bill. And then one day they told me that the HMO called up and said to the head of the family, the man said, "you haven't had a checkup lately; we'd suggest that you come in and have one." Which I thought was a good idea.

So I do think the institution is a good one. It does require more careful surveillance and examination. To that end, I am going to introduce a bill, unless you provide that in effect by regulation, to set up a community review board, primarily of senior citizens, who belong to HMOs, to give them authority, promptly—not to have to wait 30 days—to review complaints that people may have about the administration of the HMOs. I think we should have a closer relationship to what the HMOs are doing, closer surveillance, over their activities. We should keep in touch, and the people should be heard, by people who are sympathetic and knowledgeable. Just like I recommended to our former Governor that the inspectors in our nursing homes should be senior citizens. They'd be more knowledgeable of what to look for and more concerned about the care that the senior citizens are receiving. So I hope you will give consideration to setting up community review boards in every community where there are HMOs operating, composed primarily of senior citizens covered by HMOs and of course subject to medicare, giving them instant authority to deal with complaints that may be made about HMOs.

Mr. Chairman, if I may just add one other thing. I'm sorry I will not be able to stay to hear the rest of this hearing. Our distinguished representative from Florida is our State Treasurer and Insurance Commissioner; he's a fine public servant, a distinguished former Member of the House and has done a commendable job in the general supervision that the State has given to the HMOs in Florida. So others will no doubt make a formal introduction but I want to commend my honorable friend here Bill Gunter, who is the

Commissioner of Insurance and also one of the outstanding citizens of our State. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Pepper. The Chair recognizes Mr. Biaggi.

Mr. BIAGGI. Dr. Roper, how much time was given to IMC to make necessary changes in their behavior pattern after HCFA provided the corrective action plan on June 27, 1986?

Dr. ROPER. On May 30, 1986, I told them that they should supply this corrective action plan. They did in July and we stayed after them to adhere to what they told us they would do and they did not, ultimately leading to my terminating them May 1, 1987.

Mr. BIAGGI. That's almost a year, isn't it?

Dr. ROPER. Yes, sir.

Mr. BIAGGI. How can you testify the length of time, particularly in IMC's medicare share was going to 78 percent; that's 1 year, and nothing changed.

Dr. ROPER. Congressman, because during that period of time we were repeatedly told that just next week or the week after things will be better, somebody is going to come in and purchase IMC and this is all going to go away as a problem. And because the vast majority of IMC enrollees were quite satisfied with their care, and further because we were satisfied that all beneficiaries were receiving quality health care services, we chose to stick it out. Ultimately my patience ran out in March of this year and we terminated them from the program.

In retrospect, it went on too long.

Mr. BIAGGI. You said you were told. In light of the facts, it would seem to me that just accepting their comments at face value was poor judgment.

Dr. ROPER. We did not accept it at face value, sir.

Mr. BIAGGI. You were told time and time again they were correcting it. Did you have evidence of the fact they were correcting it?

Dr. ROPER. Yes. We had evidence given by the fact that we had our staff almost continually on site in Miami and Tampa reviewing what they were doing, and they were making a number of improvements. They did not slide downhill totally in that almost year time. They brought a number of things in compliance with our demands.

Mr. BIAGGI. Did the potential buyer enter into your decision?

Dr. ROPER. Sure.

Mr. BIAGGI. Why?

Dr. ROPER. Because——

Mr. BIAGGI. Because you had an existing situation that should have been corrected.

Dr. ROPER. Because the prospect of a buyer held out the idea of new capital, which they desperately needed, but especially new management. We did not have confidence in the existing management and we believed that a new firm would bring in new people with new management to oversee this plan.

Mr. BIAGGI. The focus should have been on just what they were doing, how much they were doing, was it sufficient, to correct the condition. You said that many people were satisfied; I'm sure they were. But Mr. Mica tells me that he questioned some people about the HMO and they were very happy. And he said, "have you ever

used it?" and they said no. I don't know which body is more dominant. Those that are happy because they've never used it or those that have used it. So it leaves a question.

Dr. ROPER. Let me just add another point that I mentioned in my earlier testimony. This began in the spring of 1986. In the OBRA legislation the Congress passed in October of 1986 we were given some ability to act short of a full termination. We still seek greater intermediate sanction authority, but during most of this time period we had only one choice open to us—either stick with it and try to jawbone them into shape or terminate them entirely from the program.

Mr. BIAGGI. If this condition occurred again with an HMO, would your conduct be the same, would you give them as much time?

Dr. ROPER. We wouldn't let it go on as long, no, sir.

Mr. BIAGGI. On Page 11 you mentioned additional authority you need such as imposing sanctions on organizations. Would you have used that authority against IMC?

Dr. ROPER. Surely we would have used the sanctions had we had them available. I would have used them in June of 1986, when I got there.

Mr. BIAGGI. Thank you, Dr. Roper.

The CHAIRMAN. Thank you, Mr. Biaggi. We have a vote on the floor, Dr. Roper, which means we have approximately 8 minutes in which to answer the roll call. The strategy originally was to let Mr. Mica go and then we would leave when he came back. He has not arrived, so we're going to have to recess until he does arrive and he will continue in our absence. So we'll be in recess I hope for no longer than 5 minutes.

[Recess.]

Mr. MICA. Dr. Roper, was there a failure of coordination between Federal and State officials early on in this, predating your activity or during your active involvement?

Dr. ROPER. I think it has been said earler, we had some learning to do about just what our role was, what our laws and regulations were and what the State's role and laws and regulations were.

I think we have learned a great deal and are fully coordinating what we're doing now.

Mr. MICA. Do any of the legislative recommendations that you are submitting address the coordination problem or do you feel you don't need this?

Dr. ROPER. I think we've gotten that one under control.

Mr. MICA. We didn't have a current figure on how much is owed on IMC, did we?

Dr. ROPER. Mr. Gunter I think is the one——

Mr. MICA. How many HMOs are there? And I've had this information in the past, and don't have it at my fingertips. How many HMOs are there in the United States that are federally certified, how many people are members of those HMOs?

Dr. ROPER. Are you talking about all HMOs or those that participate in medicare?

Mr. MICA. Break it down either way.

Dr. ROPER. Almost 500 federally qualified HMOs. Of those, 152 have medicare risk contracts. And in the medicare risk contract business we've got approaching 1 million medicare beneficiaries en-

rolled at the present time, by essentially every State in the Union. 34 States have medicare risk plans.

Mr. MICA. Are you having problems similar to IMC in any other regions of the country?

Dr. ROPER. No, sir.

Mr. MICA. We're obviously waiting for a few Members but let me share with you a nightmare that was real. I woke up the other night, at 2 or 3 o'clock in the morning, and couldn't sleep, so I plugged in my little earphone and listened to a radio station from somewhere in Ohio. Maybe this rings a bell. The 2 o'clock news was that an HMO had just gone bankrupt. And I thought, it's happening elsewhere.

Dr. ROPER. It happens all the time.

Mr. MICA. This is a common occurrence?

Dr. ROPER. Well, that's a flip comment, it happens all the time. But HMOs are insurance companies and businesses of all sorts are started and prosper and fail every day in this country.

Mr. MICA. They have to hold reserves to pay off debts, just like IMC.

Dr. ROPER. And they have to have insolvency insurance.

Mr. MICA. Are the reserves sufficient? Should we raise the reserve requirement, the reserve levels?

Dr. ROPER. The reserve requirements typically come about through State laws because HMOs are insurance companies under State law and the reserve requirements vary. But we believe they are adequate. Federally qualified HMOs have to meet our standards and we think those are adequate.

Mr. MICA. Should we set a minimum floor for reserve requirements that all States should meet? I assume from what you're saying that IMC has an insurance company that's going to pay off all the creditors.

Dr. ROPER. If the system works right, it will. We've got a glitch in the system right now. They have under our regulations, insolvency insurance and the insolvency insurer is trying right now to say that they terminated their insurance just at the last minute——

Mr. MICA. Are you telling us the insolvency insurance company cancelled its insurance?

Dr. ROPER. They're trying to figure a way to get out of it. Yes.

Mr. MICA. Again, does your legislation address any insolvency insurance requirements or minimums and should we? Do you think we should leave it up to the States?

Dr. ROPER. To become federally qualified, to get a medicare risk contract, we already have standards in place that I believe are adequate. You were asking about other HMOs beyond those that are federally qualified and I don't believe that there ought to be a Federal standard for those.

Mr. MICA. With the greatest respect for your opinion, I'd like to ask that you submit that to us and maybe have the committee take a look at it.

Dr. ROPER. Sure.

[The following material was subsequently received from Mr. Roper.]

INSOLVENCY PROTECTION FOR HMO/CMP MEMBERS:
FEDERAL REQUIREMENTS

1. Legislation

Sec. 1301(c) Each health maintenance organization shall--

(1)(A) have a fiscally sound operation and adequate provision against the risk of insolvency which is satisfactory to the Secretary.

(B) adopt at least one of the following arrangements to protect its members from incurring liability for payment of any fees which are the legal obligation of such organization.

(A) a contractural arrangement with any hospital that is regularly used by the members of such organization prohibiting such hospital from holding any such member liable for payment of any fees which are the legal obligation of such organization;

(B) insolvency insurance, acceptable to the Secretary;

(C) adequate financial reserve, acceptable to the Secretary; and

(D) other arrangements, acceptable to the Secretary, to protect members.

except that the requirements of this paragraph shall not apply to a health maintenance organization if applicable State law provides the members of such organization with protection from liability for payment of any fees which are the legal obligation of such organization.

Sec. 1876(b) For purposes of this section, the term "eligible organization" means a public or private entity (which may be a health maintenance organization or a competitive medical plan), organized under the laws of any State, which--

"(1) is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act), or

"(2) meets the following requirements.

(E) The entity has made adequate provision against the risk of insolvency, which provision is satisfactory to the Secretary.

2. Regulations (applicable to both HMOs and CMPs)

Sec. 110.108(a)(1) Each HMO shall have a fiscally sound operation as demonstrated by:

(iv) A plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which payment has been made and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge.

(a)(3) Protection of members. (i) Each HMO shall adopt and maintain arrangements satisfactory to the Secretary to protect its members from incurring liability for payment of any fees which are the legal obligation of the HMO. These arrangements may include:

(A) Contractual arrangements with health care providers used by members of the HMO prohibiting the providers from holding any member liable for payment of any fees which are the legal obligation of the HMO;

(B) Insurance, acceptable to the Secretary;

(C) Financial reserves, acceptable to the Secretary, that are held for the HMO and restricted for use only in the event of insolvency; or

(D) Any other arrangements acceptable to the Secretary.

(ii) The requirements of this paragraph do not apply to an HMO if the Secretary determines that applicable State law provides that members of the HMO may not be liable for payment of any fees which are the legal obligation of the HMO.

3. Federal Guidelines

See attached Insolvency Protection Policy Issuance

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

OHMO Rm. 9-11 Parklawn Bldg.
Rockville, MD 20857

MAY 16 1986

OHMO Program Information Letter
86-02

INSOLVENCY PROTECTION

Background

The HMO Act (Title XIII of the Public Health Service Act) and its implementing regulations (at 42 CFR Part 110) require (1) a plan for handling insolvency which allows for continuation of benefits (Section 110.108(a)(1)(iv)), (2) arrangements to protect members from incurring liability for payment of any fees which are the legal obligation of the HMO (Section 110.108(a)(3)), and (3) the maintenance of a fiscally sound operation (Section 110.108(a)(1)). The determination of an HMO's fiscal soundness or its ability to maintain an ongoing operation and, therefore, avoid insolvency, involves a careful analysis of the HMO's balance sheet, profit and loss position, and its ability to maintain sufficient cash flow and adequate liquidity to meet obligations as they become due. Demonstration of fiscal soundness at any point in time, however, can never eliminate the risk of insolvency. Therefore, while the maintenance of a fiscally sound operation is important in management's efforts to prevent insolvency, Sections 110.108(a)(1)(iv) and 110.108(a)(3) specifically address the HMO's plans and arrangements for protecting members when insolvency occurs. This distinction is material to the development of OHMO's insolvency protection requirements.

The insolvency protection requirements for competitive medical plans (at 42 CFR Section 417.407(c)(5)) are identical to those for federally qualified HMOs. Therefore, all references to HMO requirements are applicable to CMPs as well.

The implementation of the Federal insolvency protection provisions are based on consultation with the National Association of Insurance Commissioners and an understanding of the provisions in the NAIC's model state HMO law concerning insolvency protection arrangements. Specifically, OHMO has adopted the NAIC's principle of "uncovered" expenses and the requirement for restricted funded reserves based on the amount of uncovered expenses.

Uncovered expenses are the costs of health care services that are offered by an HMO for which an enrollee would also be liable in the event of the organization's insolvency. These are expenditures for health care services for which the HMO is at risk. They will vary in type and amount, depending on the arrangements of the HMO. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the enrollee even though the provider is not paid by the HMO, or for services that are guaranteed, insured or assumed by a person or organization other than the HMO.

Basic Requirement

The basic requirement, to demonstrate compliance with the insolvency protection provisions under the HMO Act and regulations, is that an HMO must evidence arrangements for continuation of benefits to members and protection of members from HMO liabilities. To satisfy this requirement, an HMO must demonstrate that it has arrangements in place to cover at least two months of health care expenses in the event it becomes insolvent.

One month would cover health care expenses incurred prior to the date the HMO was declared insolvent. This recognizes that a failing HMO will be behind in paying its bills. (Note - an HMO may be behind in paying its bills by more than one month, but OHMO believes a reasonable way to meet the HMO Act requirements is to cover one month's bills).

The second month would cover health care expenses after the HMO was declared insolvent for the continuation of benefits for the duration of the contract period for which payment has been made and for the continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge.

Arrangements to Cover Expenses

An HMO may make various arrangements to cover health care expenses. These arrangements are reviewed for sufficiency. Examples of such arrangements follow.

1. Insolvency insurance. HMOs often buy an insolvency rider to their reinsurance contracts which covers the expenses to be paid for continued benefits after insolvency. In order for the second month's expenses to be considered fully covered, the policy must continue benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge, and for the duration of the contract period for which payment has been made. If deductibles applicable to the reinsurance portion of the policy are applied to the insolvency benefit, the expenses are uncovered to the extent the deductible applies.

   Some insolvency insurance policies exclude coverage for Medicare beneficiaries enrolled in an HMO. Because Medicare beneficiaries will be immediately converted to fee for service in the event of an HMO insolvency, the expenses after insolvency for Medicare basic benefits will be considered covered. However, any supplemental benefits which the HMO provided to Medicare beneficiaries will be considered uncovered unless the insurance policy or other arrangement continues those benefits.

2. Hold harmless provisions. HMOs often cover many of the expenses incurred prior to insolvency by including in their provider agreements "hold harmless" provisions obligating the provider to look only to the HMO and not under any circumstances to bill or otherwise claim compensation from the HMO's enrollees for payment of covered services. The National Association of Health Maintenance Organization Regulators (NAHMOR) and the National Association of Insurance Commissioners (NAIC) have adopted guidelines to assist HMOs and their regulators in the area of hold harmless provisions. A copy of the guidelines is included in OHMO Program Information Letter 86-01, issued on February 5, 1986. If a federally qualified HMO elects to use hold harmless provisions to cover expenses, use of the first two paragraphs of the sample provision at the end of the guideline has been found acceptable by OHMO. Alternative language proposed for such use should adhere to the guideline.

HMOs that capitate a medical group for all physician services, including some specialty services provided outside the group, have inquired whether hold harmless provisions in the HMO/group agreement will cover all physician expenses for the month prior to insolvency. Since specialist physicians outside the group are not legally obligated by that agreement to look only to the HMO or the group for payment for services, those expenses will be considered uncovered unless the specialist physicians themselves have entered into acceptable hold harmless agreements or other acceptable arrangements to cover those expenses have been made.

3. Continuation of benefits provisions. In some cases provider contracts include language that obligates the provider to provide services for the duration of the period after the HMO's insolvency for which payment has been made (typically, up to one month) and until the enrollees' discharge from inpatient facilities. Continuation of benefits provisions are much less common than hold harmless provisions, and will be considered to cover expenses only when the language is clear that the provision of services and the member protection are intended to apply after the HMO's insolvency.

4. Letters of Credit. Federally qualified HMOs may make use of a bank letter of credit to meet a portion of their insolvency protection responsibilities. A bank letter of credit used for these purposes is essentially a surety bond and is to be distinguished from a bank line of credit, which is used to fund ongoing operations. Only a maximum of 50% of the estimated amount of uncovered expenses may be covered by the letter of credit. The remaining 50% must be covered through other arrangements. Criteria for letter of credit acceptability to OHMO and samples of acceptable letters of credit are included in OHMO Program Information Letter 85-02, issued on November 25, 1985.

5. Restricted State Reserves. Many States have fiscal requirements that HMOs restrict a portion of their reserves to protect enrollees in the event of an HMO's insolvency. If these reserves are legally restricted, they may be used to cover expenses and meet Federal insolvency requirements. Ordinarily, such restricted reserves are on deposit with a state official, such as the State Treasurer, and may not be obtained by the HMO to finance operating deficits. If the State reserve requirement is only a balance sheet surplus or equity requirement and the funds are not legally restricted, the reserves may not be used to cover expenses for purposes of the Federal insolvency requirements.

6. Guarantees. Guarantees from third parties require some discussion. In all cases where there are third party guarantees, the guarantor will be analyzed to assure that it has finances to cover the estimated uncovered expenses. However, a distinction is made between regulated and nonregulated guarantors with respect to the extent to which the guarantee may cover the uncovered expenses.

   a. Regulated Guarantors. If the guarantor is a regulated insurance company and OHMO determines that the guarantor has adequate finances to cover the uncovered expenses, then the guarantee may be used to cover all of the HMO's uncovered expenses.

b. Nonregulated Guarantors. If the guarantor is not a regulated insurance company, then its guarantee will be accepted without the need for a restricted reserve only when the guarantor has achieved an adjusted net worth (net worth (total assets less total liabilities) minus intangible assets minus lines of credit minus guarantees) of at least $500 million. If the nonregulated guarantor has not achieved an adjusted net worth of at least $500 million, then in order to substantiate the guarantee, it is required that the guarantor restrict a portion of its assets equivalent to the value of expenses that the guarantor is agreeing to cover.

If the guarantee arrangement is for more than one HMO, the guarantor will need to restrict a reserve equal to the larger of (1) the expenses for the HMO with the largest amount, and (2) 50% of the sum of expenses to be covered for all the HMOs under the arrangement, provided that the adjusted net worth (as defined above) of the guarantor is at least twice the sum of the expenses to be covered. If the adjusted net worth of the guarantor is less than twice the sum of the expenses to be covered, then the guarantor must maintain 100% of all the HMOs' uncovered expenses in a restricted reserve.

7. Net Worth. The net worth of an HMO will be accepted to reduce the amount of or the need for a restricted reserve when the HMO has demonstrated sufficient net worth and an adequate history of generating net income. To be considered as having had an adequate history of generating income, the HMO must have had a cumulative net operating surplus during the three most recent fiscal years, and a net operating surplus during the most recent fiscal year.

To calculate the sufficiency of net worth, the minimum requirements are $1 million excluding land, buildings, and equipment and $5 million including land, building and equipment. If the HMO's adjusted net worth (as defined above) is less than $35 million, then for each whole unit of $250,000 of net worth in excess of the minimum requirements ($1 million or $5 million, as applicable), $100,000 of the excess can be used to cover uncovered expenses. If the HMO's adjusted net worth is at least $35 million, then all of the excess net worth can be used to cover uncovered expenses.

8. State Law. The requirements discussed above do not apply to an HMO if OHMO determines that applicable State law provides that members of the HMO may not be liable for payment of any fees which are the legal obligation of the HMO.

Calculation of Uncovered Expenses

After considering all contractual arrangements and restricted State reserves to cover expenses, the amount of expenses uncovered is calculated. Attached are two uncovered expenses calculation work sheets. Attachment A is for use by HMOs applying for Federal qualification. Attachment B is for use by federally qualified HMOs applying for expansion of their qualified service areas. This attachment is also used for ongoing compliance monitoring. The HMO must make arrangements to establish a funded restricted reserve equal to the value of the uncovered expenses for the protection of the HMO's members in the event of an insolvency.

Restricted Reserve. If the HMO already has on deposit with a State a restricted reserve established to meet the State's reserve requirements but the amount is not sufficient to cover the HMO's uncovered expenses, the HMO may deposit additional sums with the State to cover those expenses if the State is willing to hold the additional reserves. The other approach frequently used by HMOs to fund a restricted reserve is to establish a Trust Agreement with a bank whereby funds are deposited into the account for use only in the event of the HMO's insolvency. It is essential that the principal not be available for use by the HMO to fund ongoing operations. The Trust Agreement should provide that approval of the State or OHMO is required before disbursements can be made from the reserve.

Frank Seubold

Frank H. Seubold, Ph.D.
Associate Director for
Health Maintenance Organizations

Attachments

Attachment A

HMO QUALIFICATION

Uncovered Expenditures Calculation Worksheet

I. Total Health Care Costs		Amount	
1.	Total year's health care costs following anticipated qualification	_____	
2.	Line I.1 divided by 12	_____	
3.	Total costs for two months (line I.2 x 2)		_____

II. Covered Expenditures (Explain each item)

		Month before insolvency	Month after insolvency	Total	
1.	Insolvency insurance	XXXX	_____	_____	
2.	Hold harmless contracts (hospitals, physicians)	_____	XXXX	_____	
3.	Continuation of services provisions in provider contracts	XXXX	_____	_____	
4.	State restricted reserves	XXXX	XXXX	_____	
5.	Guarantees	_____	_____	_____	
6.	Other arrangements	_____	_____	_____	
7.	Total	_____	_____		_____

III. Uncovered Expenditures (Line I.3 minus Line II.7) _____

Attachment B

HMO Expansion

Uncovered Expenditures Calculation Worksheet

		Qualified Areas*	New Area**	Total
I.	Total Health Care Costs			
	1. Total year's health care costs			
	2. Line I. divided by 12			
	3. Total costs for 2 months (Line II. 2 x 2)			
II.	Covered Expenditures (Attach explanation for each item)			
	1. Insolvency insurance			
	One month after insolvency			
	2. Hold harmless contracts			
	One month before insolvency			
	3. Continuation of services provisions in provider contracts			
	One month after insolvency			
	4. State restricted reserves			
	5. Guarantees			
	6. Other			
	7. Total			
III.	Uncovered Expenditures (Line I.3 minus Line II.7)			

(*) Calculate uncovered expenditures for the qualified areas based on the most recent fiscal year or year end statement, if more current.

(**) Calculate uncovered expenditures for the proposed expansion for the 12-month period following anticipated qualification.

Mr. MICA. Florida has been a leader. We have usually been ahead of the curve, not only in these types of problems but in the solution. We're dealing with 49 other States and it seems to me that if there is a possibility of more and more HMO's. You just said HMOs go broke all the time, and that we ought to have, within reason, the stiffest reserve requirements that we can impose.

Dr. ROPER. If I could just take another minute, let me make sure I'm clear. For HMOs that are federally qualified, certainly for HMOs that have medicare contracts, there is a Federal interest to make certain that they are financially solvent, including having reserve requirements and insolvency insurance.

We already have those requirements in place and feel that they are adequate.

For plans that are not federally qualified and do not do business with the medicare program, I don't believe that the Federal Government as a rule should be regulating the insurance industry in America.

Mr. MICA. Dr. Roper, I'm going to ask unanimous consent and I'll bet I get it, that the record be left open to submit additional questions for the committee and we'd appreciate your responding as quickly as possible on those. Because of time, we have guests from out of State that we'd like to get before the committee. We're going to just stop right here. We expected another Member to be back for questioning. Maybe you could wait just a few minutes in case he has additional questions, and we'll proceed with the second half.

Dr. ROPER. OK.

Mr. MICA. Thank you.

Our second panel will consist of witnesses who have a great interest in the future of the medicare HMO program, the entire program, and who bring us valuable perspectives for consumers, States, HMOs and researchers.

The first witness, and I'd like to ask you each to take the table as I call your name—Don Reilly. Mr. Reilly. Well, I understand Mr. Reilly now has had to catch a plan. Take that off the end there.

He will be represented by Eva Skinner. Eva is a member of the Board of Directors of the American Association of Retired Persons.

Ms. Skinner resides in Mr. Roybal's home city of Los Angeles, California. Ms. Skinner is representing the Leadership Council of Aging Organizations today.

I don't see it on here, but I know he's here. The Insurance Commissioner of the Great State of Florida, an individual who has been renowned more recently as the owner of the largest HMO in Florida, if temporarily, Bill Gunter, from our State. Commissioner Gunter.

Incidentally, obviously, Commissioner Gunter's office is in charge of oversight and regulatory activities with regard to all HMOs in the State of Florida.

Robert Crane is the Vice President of the Kaiser Foundation, a health plan in Oakland, California. As all of you know, the Kaiser HMO program is the father of today's HMO plans and represents a commitment that we expect from all of our HMOs. And I might tell you that many, many years ago, sir, I reviewed your plans in my previous employment and we found it to be a phenomenal approach.

Kathryn Langwell is a Senior Economist with the Mathematica Policy Research in Washington and has been Project Director on a number of Medicare Capitation and Competition Evaluations and research projects, and I'll bet she has all the answers. Or maybe some.

With that, I think we have the panel and what I'd like to do is ask Commissioner Gunter if he would lead off at this time. I know we have some tight schedules here. And I would advise each of the witnesses, your entire written testimony will be included in the record. If you care to summarize, we'd be happy to have you do that.

Commissioner Gunter.

TESTIMONY OF BILL GUNTER, INSURANCE COMMISSIONER, STATE OF FLORIDA, TALLAHASSEE, FL, ACCOMPANIED BY BOB JOHNSON, CHIEF, BUREAU OF ALLIED ALLIANCE

Mr. GUNTER. Thank you very much, Mr. Chairman. I have also asked Mr. Bob Johnson, who is the Chief of our Bureau of Allied Alliance, which has HMO oversight, to join us on this particular panel.

As you know, recent events surrounding the late International Medical Center's HMO, has stirred great controversy around the question of HMOs generally, whether they are a good thing and whether the HMO-medicare relationship that has grown up will be a lasting one.

Speaking as one who is in the thick of the battle for hospital cost containment in the late 1970's and early 1980's, I would cast my vote for the continuation of the HMO concept in general and the medicare-HMO concept in particular.

I do so however with this reservation. That HMOs which came into the world of fair haired children, spared by legislative design from the regulatory oversight that was the lot of insurers and health care providers must now, Mr. Chairman, in their maturity, assume that burden in full.

Most States have exempted HMOs from more restrictive regulation, partly as a consequence of Federal pre-emption of State laws that came with the passage by the Congress of the 1973 Federal HMO Act designed to promote HMO development, and set some minimum standards. The Florida solvency laws and those of other States need to be strengthened further. Solvency and quality of care laws today represent an advance over earlier legislation. Florida's first HMO law passed in 1972, took up just 6 pages in our statute books. Today the law takes up 23 pages with more to come from the 1987 session.

Clearly the early legislative intent of a laissez faire mode has been overtaken by the needs of Florida's current 1 million HMO subscribers.

The 1987 legislative session just adjourned significantly increased our authority to fine HMOs for the late financial submission of reports and authorize the additional sanction of suspension of new enrollment for violation of HMO statutes.

Naturally we're heard complaints from some HMOs about this tougher regulation. It reminds me of the story of a patient who

complained to his doctor about the strict regimen he had been put on. "Before you complained too much," said the doctor, "I want to tell you how strongly tempted I was with a condition as serious as yours, to let the case go to autopsy." In the course of time, some HMOs have gone to autopsy. IMC among them. And I understand it is our purpose here to conduct at least a part of that autopsy.

In 1977, and then again in 1986, the Florida Department of Insurance moved to force IMC to live up to its solvency responsibilities. In the last weeks, we lived with IMC until we felt the pulse fade. Finally we asked the circuit court to pronounce the patient dead.

Florida moved quickly to preserve coverage for IMC's more than 170,000 enrollees. That response later emerged from judicial scrutiny with personal praise from the presiding Judge. Still, in the aftermath, we find ourselves taking lessons out of the records of IMC and looking for ways to strengthen our oversight in the next legislative session.

We have many concerns with health maintenance organizations. Not the least of these is setting standards for quality of care, Mr. Chairman. The nature and organization of HMOs subject them to pressures to cut costs, to cut these costs in ways that may not serve the best interests of subscribers. My office has long received HMO quality of care complaints, and been frustrated in efforts to see those complaints resolved.

We have designed and are now implementing an HMO subscriber assistance program to see that HMO members have recourse if they don't get the care they require from their HMO. This is along the lines of the legislation which Senator Pepper mentioned earlier in testimony. The rules state that each HMO must have internal grievance machinery and report unresolved grievances within fixed time limits.

In addition to those administrative actions, a new quality of care statute was adopted at my suggestion in the 1987 legislature requiring health care provider certification for HMOs along with an internal quality assurance program and external reviews every 3 years.

We have also taken steps to deal with unsavory HMO marketing practices. First, we've issued emergency rules to prevent the practice of twisting or changing an HMO enrollee's membership from one HMO to another without the enrollee's knowledge in order for the salesperson to make a commission.

Second, we are considering legislation requiring the licensing of HMO sales representatives. The concern that I have in this area is to avoid the creation of a scenario in which the HMO might be able to absolve itself of responsibility and accountability for the unsavory sales practices of its marketing representatives because they are licensed and regulated by the State.

At the Federal level, I think Dr. Roper has already indicated that lessons have emerged from the IMC experience. First, in respect to any suggestions I might have, I would concur that the waiver of the 50–50 ratio between medicare and nonmedicare subscribers is to be used only very sparingly. Certainly when you look at the experience of IMC, that waiver was questionable to be sure.

Second, the Federal Government needs more options for dealing with Medicare HMOs than just the cancellation of the medicare contract with a 90-day notice.

Considering the financial stake that it has in medicare HMOs, and I know these changes are being considered by the administration and the Congress at the present time.

I'm also concerned about the revolving door phenomenon where employees with regulatory responsibilities on either the Federal or the State levels end up with jobs in the industries they regulate without any kind of statutory waiting period.

In the final analysis, both the State and the Federal Government have a stake in the surviveability of the HMO concept of wellness and preventive care. HMOs that take their mission seriously and perform well have a real place in a Nation where health care costs have swelled to 12 percent of the GNP which is more than $450 billion a year.

Together, I think we must find a way to make sure that these health care alternatives are viable so we can deliver on the promise of medicare: a promise of affordable and accessible quality health care for our Nation's retired and elderly. With the continued constructive support of the Congress, I believe that we can succeed.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Gunter follows:]

PREPARED STATEMENT OF BILL GUNTER, INSURANCE COMMISSIONER, STATE OF FLORIDA

Mr. Chairman, Members of the Committee.

The recent events surrounding the late International Medical Centers HMO has stirred great controversy around the question of HMOs generally: whether they are a good thing and whether the HMO-Medicare relationship that has grown up will be a lasting one.

Speaking as one who was in the thick of battle for hospital cost containment in the late 70s and early 80s, I cast my vote for the continuation of the HMO concept in general and the Medicare-HMO concept in particular. I do so, however with this reservation:

That HMOs, which came into the world as fair-haired children, spared by legislative design, from the regulatory oversight that was the lot of insurers and health care providers, must now, in their maturity, assume that burden in full.

Most states have exempted HMOs from more restrictive guidelines, partly as a consequence of federal preemption of state laws that came with passage by Congress of the 1973 Federal HMO Act designed to promote HMO development and set minimum standards.

Nevertheless, all but two of the fifty states have specific HMO enabling legislation and the trend is growing toward stricter state regulation. 27 states currently require deposits with the state insurance commissioner. The reserve amount ranges from $100,000 to $250,000 for most states.

In 1986, with HMOs covering more than a half-million people in Florida, the Legislature set HMO surplus requirements at $100,000 or five percent of liabilities, whichever was greater, and insolvency protection at $100,000 or twice the HMO's estimated average uncovered expenditures.

That legislation required HMOs to make quarterly financial reports when deemed necessary by the Department of Insurance. It also required that every HMO contribute $10,000 to an expense fund to help rehabilitate insolvent HMO's. In retrospect, it's clear that the expense fund contribution is inadequate for practical purposes, and my office is working on ways to increase that fund.

Although Florida's solvency laws, and those of many other states, need to be strengthened in a number of ways, the solvency legislation of 1985 was an advance over earlier legislation.

Florida's first HMO law, passed in 1972, took up just six pages in the statute books. Today the law takes up 23 pages. The original hands-off approach spelled out in the statute's declaration of intent is now in conflict with the both body of existing law and the needs of what have become one million HMO subscribers in Florida.

Clearly we need more teeth in state law to regulate for solvency. We need more, for instance, than the specified $250 per day fine for late filing of annual reports and we need to do away with the 90-day time-out HMOs get each time we question an asset shown on that report. Our early legislation was hard won, but now it needs to be strengthened.

Naturally, we've heard complaints from some HMOs about tougher regulation. It reminds me of the story of a patient who complained to his doctor about the strict regimen he had been put on.

"Before you complain too much," replied the doctor, "I want to tell you how strongly tempted I was, with a condition as interesting as yours, to let the case go to autopsy."

In the course of time, some of them have gone to autopsy, IMC among them and I understand it as our purpose here to conduct at least a part of that autopsy.

The IMC story covered a span of 15 years. It was the third of what have become 46 Florida HMOs. Its epitaph is written in the newstories we see daily. It tells of a popular concept poorly executed. It had vigorous defenders, including many of its subscribers, and staunch critics, also including many of its subscribers.

In 1977 and 1986, the Florida Department of Insurance was forced to step in to force IMC to live up to its solvency responsibilities. In the last weeks we lived with it and held its hand until we felt the pulse fade. Finally we asked a circuit court to pronounce it dead.

Florida moved quickly to preserve coverage for IMC's more than 170,000 enrollees. That response later emerged from judicial scrutiny with personal praise from the presiding judge. Still, in the aftermath, we find ourselves picking lessons out of the wreckage IMC left behind and looking for ways to apply them to our 1988 legislative agenda.

We have other concerns with the institution of the health maintenance organizations. Not the least of these is setting standards for quality of care. The nature and organization of HMOs subject them to pressure to cut costs in ways that may not serve the best interests of the subscriber. My office has long received HMO quality-of-care complaints and been frustrated in efforts to see those complaints resolved.

This past spring, we established, by administrative rule, an HMO Subscriber Assistance Program to see that HMO members have recourse if they don't get the care they need from their HMO. The rules state that each HMO must have internal grievance machinery and report unresolved grievances within fixed time limits.

In addition to those administrative actions, a new quality of care statute was adopted in the 1987 Legislature requiring that required health care provider certification for HMOs, along with an internal quality assurance program and external review each three years.

We are also concerned about HMO marketing practices. We have recently fined two Florida HMOs for allowing the practice of "twisting" by their sales representatives and issued emergency rules to prevent it in the future. Twisting involves changing a Medicare HMO enrollee's membership from one HMO to another without the enrollee's knowledge in order to take the commission.

We are considering legislation for presentation to the next Florida Legislature to require the licensing of HMO sales representatives.

I think Dr. Roper would agree that lessons have emerged from the IMC experience for the federal government as well. The waiver of the 50/50 ratio between Medicare and nonMedicare subscribers was done for reasons that were understandable at the time but certainly should be avoided in the future. The wisdom of that ratio has been amply borne out in the IMC experience.

Clearly too, the federal government needs more options for dealing with Medicare HMOs than cancellation with 90-day notice, considering the stake it has in HMOs as health care providers for the Medicare program.

I'm also concerned about the "revolving door" phenomenon where employees with regulatory responsibilities on either the federal or the state level end up with jobs in the industries they regulate without any kind of statutory waiting period.

We need to keep a handle on uncontrolled growth. We may also need to find a way to control runaway administrative costs as a percentage of total expenditures. Certainly IMC's 23 percent administrative cost – as opposed to about 17 for other Florida HMOs – was central in its downfall.

In the final analysis, both the state and the federal government have a stake in the surviveability of the HMO concept of wellness and preventive care. HMOs that take their mission seriously and perform well have a real place in a nation where health care costs have swelled to 12 percent of the GNP, more than $450 billion a year.

Together, we will have to find the way to make these health care alternatives viable so we can deliver on the promise of Medicare: affordable and accessible quality health care for our nation's retired and elderly.

Mr. MICA. Thank you, Mr. Commissioner. We'll now proceed with Eva Skinner, as I indicated earlier, a member of the Board of Directors of the American Association of Retired Persons.

TESTIMONY OF EVA SKINNER, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP), LOS ANGELES, CA, REPRESENTING THE LEADERSHIP COUNCIL OF AGING ORGANIZATIONS, WASHINGTON, DC

Ms. SKINNER. I would like to submit Mr. Reilly's remarks for the record.

Mr. MICA. Without objection, it will be included in the record.

Ms. SKINNER. Thank you.

[The prepared statement of Mr. Reilly follows:]

PREPARED STATEMENT OF DONALD REILLY, LEADERSHIP COUNCIL ON AGING

On behalf of the Leadership Council on Aging, I appreciate this opportunity to share with the House Aging Committee our perspective on the status of HMOs serving Medicare beneficiaries.

HMOs are an option that hold much promise for older consumers. They offer comprehensive benefits for a prepaid fee. They provide coordinated health care, and many provide more services than currently covered by the Medicare program. HMOs handle the paperwork that is confusing and burdensome for many older consumers. Some HMOs provide a wide variety of services within one medical facility.

Along with that promise comes several expectations. Medicare consumers expect that the government will contract only with high quality health care providers and that the Health Care Financing Administration will exercise appropriate supervision over HMOs as they serve Medicare beneficiaries. Consumers also expect that Congress will require reasonable levels of accountability, consumer protection and consumer information. Consumers expect that truthful information will be available to help them understand the HMO option before they join, and consumer organizations expect to have a role in providing useful information about HMOs to their constituents.

As HMOs mature, we see that some but not all of these expectations are being met. Today I'd like to briefly enumerate some elements that need to be in place in order for HMOs to meet the expectations of the consumer community. Eva Skinner will then expand on areas where strengthening is needed in federal law and regulations pertaining to HMOs and Medicare.

Quality of Care Reviews

An effective and comprehensive quality of care review program is essential to build beneficiary trust in the concept of prepaid health care. While we realize that most HMOs provide adequate and appropriate care, we have witnessed harmful and intolerable actions

by a few HMOs. These examples justify the need for comprehensive quality of care monitoring.

This monitoring program cannot be implemented overnight. HCFA's recently signed review contracts are a much-needed first step in this direction. We anticipate that additional requirements and scope of review activities will evolve over time as all parties in the health care arena become more skillful in evaluating quality of care. The aging network intends to be involved in this process and in the dissemination of the findings of these reviews.

Consumer Information

Readily available, relevant information about HMOs is crucial to permit consumers to make well-informed choices about HMOs. They need to know about their rights and responsibilities before joining an HMO. They also need to know about the benefits, premium, and service delivery system.

We have seen that reliance on the marketing efforts of HMOs alone is not sufficient to ensure that beneficiaries receive adequate information on which to make a well-informed decision. The aging network encourages HCFA and the Congress to permit further demonstration of 3rd-party demonstration programs that provide consumer information about prepaid health care plans.

HMO Staffing/Social Service Programs

As HMOs become providers of health care for Medicare beneficiaries, it is important that they become more familiar with the special needs of older patients and to adapt their health care delivery systems accordingly. The aging network suggests that HMOs need to hire staff with training in geriatric medicine, or to provide special training for their medical and support personnel.
A positive step toward promoting Medicare member access and understanding about the HMO is the establishment of a separate Medicare members services department.
HMOs also need to become familiar with the network of support and social services that exist within their communities. HMOs do not need to become the provider of every service needed by older patients. They do, however, need to know of their availability and how the HMO or the patient can arrange for services.

We encourage HMOs to devote increased attention to this aspect of health care delivery as they expand their services to older consumers.

Changes in Premium and Benefits

Beneficiaries need adequate notice when an HMO is changing its premium, benefits package, or provider network so they can decide whether to continue their HMO membership. The notification period becomes even more important when an HMO has decided to voluntarily terminate its contract with the Medicare program.

Our experience with HMOs shows that additional protections are needed in this area. HMOs have complied with federal regulations regarding member notification, however beneficiaries have had a gap in health coverage if they changed back to fee-for-service health care. The aging network urges Congress to strengthen provisions regarding an HMO's obligation when the HMO voluntarily terminates its contract with Medicare.

Because beneficiaries vary widely in their financial resources and ability to pay for health care, we believe a range of affordable benefits packages should be available. Low option plans covering the basic services required by Medicare need to be available for beneficiaries who can afford only a small premium each month.

Conclusion

The Leadership Council on Aging appreciate this opportunity to begin examining how Medicare beneficiaries are faring in prepaid health care plans. We look forward to continuing this discussion in the future.

Ms. SKINNER. Good morning, Mr. Chairman, staff and visitors.

I am Eva Skinner and I am a member of the American Association of Retired Persons. AARP is a member of the Leadership Council on Aging and I'm accompanied this morning by Stephanie Kennan of AARP's legislative staff.

There is increased government interest in using capitation for medicare reimbursement of medical services. We are pleased that HMOs are showing an interest in serving medicare beneficiaries, and beneficiaries strongly support this option. However, as we learn more about serving the beneficiaries through HMOs and CMPs, we hope that Congress, beneficiaries and the Health Care Financing Administration, will work together to learn from the past and strengthen the program so it remains a viable option.

My written statement cover a variety of concerns and include recommendations. This morning, however, I will focus on quality of care, marketing practices, and enrollment issues.

Many HMOs are delivering high quality of care. We find many similarities between the prospective payment system under which hospitals are reimbursed and the way in which HMOs are reimbursed. There are incentives at the provider level which should result in the use of less costly care.

However, there are also incentives to skimp on care or limit access to care. Because of these similarities we believe that an analogous method of review of care under the prospective payment system should be applied to the HMOs.

We do not believe that this will be the case with the new quality of review system that is being put into place now. As a member of the Board of Directors of the California Peer Review Organization, I am familiar with the quality of care reviews as they have existed and as it is planned for the HMOs.

On the positive side, we are pleased at reviews that examine a broad base of indicators for data on quality of care problems. We are pleased to see that in person peer reviews are required to include medical records for ongoing care and for certain conditions with hospital care.

Reviews must include complete patient records from all settings that may indicate inadequate or inappropriate care.

There are, however, serious flaws. Beneficiary access to health care will not be measured. We recommend that admissions to the hospitals through emergency rooms be examined. This would be an excellent indicator of whether beneficiaries' access to the HMO/CMP was limited or if appropriate care may have been given.

We are also distressed that the decisions about the level of medical record review will be based on review organizations' assessment of each HMO, CMP's internal quality assurance program rather than on an initial uniform and comprehensive review of medical outcomes in each HMO.

This approach is inconsistent with HCFA's methodology for review for hospital care. Beneficiaries support an approach that would target reviews based on HMO/CMP data and performance. We support development of a review program that will direct more resources toward health plans that are providing less quality of care. We hope to work with you to further our knowledge about quality of care and to apply that to reviews of HMO care.

The next issue I would like to discuss is the HMO marketing practices. Consumers need information to accurately assess whether a particular HMO is appropriate for them. Therefore, information received through marketing practices is key. We are concerned when we learn of marketing practices designed to screen the population. Many HMOs host events such as dances which attract only ambulatory, active and more healthy individuals. In other cases, HMOs require in-person interviews in their offices and while enrollment solely through an in-person interview ensures that members receive a thorough explanation of the health plan operations and obligations it can also screen out individuals with health problems. We question these kind of tactics and believe the HMOs should serve all beneficiaries. There have been some instances in my home State where some of the HMOs in their very aggressive marketing have gone from door to door to enroll people, which I understand is highly illegal. Although HCFA has the responsibility of enforcing marketing and enrollment practices, this has shifted by default in many areas to the State insurance departments or consumer protection division of State attorneys general. We recommend one, that HCFA should establish minimum standards for written marketing and membership material developed in consultation with beneficiaries, in communities where English is not the primary language of 5 percent of the population, HCFA should require materials be printed in the relevant languages. We recommend that that material be printed in large, bold print. Three, HCFA should require HMO/CMPs to make their membership rules available for examination prior to enrollment. Lists of available doctors should also be provided.

The last issue I would like to discuss today is coordinated, open enrollment. HCFA is required by statute to establish a single 30-day period each year during which all HMOs in a given geographic area must allow open enrollment. To date we have not seen the draft regulations from HCFA. Coordinated open enrollment would help resolve some of the problems regarding coverage gaps that occur when an HMO terminates its contract with medicare. When an HMO ceases to offer medicare risk option, beneficiaries face gaps in coverage for preexisting conditions because medigap policies have a 3 to 6 month waiting period to cover these conditions.

We believe that in instances like this the HMO should be responsible for all costs incurred for care due to preexisting conditions while that individual is subject to the waiting period for coverage.

We also feel that much more attention should be paid by all the HMOs and HCFA to the staffing patterns of the HMOs, that the ratio of staff to the number of patients who need to be served will determine the ability of that HMO to serve these people and to make certain that they have adequate health care. I feel that there should be standards in existence throughout all the HMOs that would have a designated ratio of various disciplines of staff to the numbers of patients who have been enrolled because we're finding more and more that this has been the case where an HMO will enroll large, large numbers of patients and then not have the staff to enable them to deliver the services that are needed.

Mr. Chairman, there are a variety of issues concerning premium increases, information and HMO staffing, which are discussed in

detail in my written statement. We look forward to working with you, to further improve the HMO option.

I thank you.

[The prepared statement of Ms. Skinner follows:]

PREPARED STATEMENT OF EVA SKINNER, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP)

Good morning Mr. Chairman. My name is Eva Skinner. I am a member of the Board of Directors of the American Association of Retired Persons (AARP). AARP is a member of the Leadership Council on Aging (LCOA). We are pleased to have this opportunity to comment on the current status of HMOs serving Medicare beneficiaries.

There is increasing interest in using capitation, or fixed prepaid amount, for Medicare reimbursement of medical services. From the beneficiary's perspective, capitation enhances the likelihood that consumers will have access to more health services than currently covered by Medicare at a cost comparable to or less than Medicare supplemental insurance. Beneficiaries appreciate the freedom from filing Medicare and insurance claims, and the ability to budget more accurately for their health care expenses. HMOs also have the potential to improve coordination of patient care. From the government's perspective, capitation provides predictability of budget outlays and changes incentives at the provider level which should result in the use of less costly care. The evidence is reasonably persuasive that capitated practice achieves economies, particularly by reducing hospital admissions and total hospital days. Performance in other areas approximates medical practice more generally.

The most common application of capitation payments is for health maintenance organizations (HMOs) and competitive medical plans (CMPs) with Medicare risk-contracts. (As of May, 1987, 152 HMOs/CMPs had signed risk-contracts with the Medicare program, and nearly 914,715 beneficiaries had enrolled.) Under these contracts, Medicare pays a fixed, predetermined amount for each beneficiary who enrolls. The capitation amount is equal to 95 percent of the average adjusted per capita cost (AAPCC) that Medicare spends on the fee-for-service system within defined geographic areas.

Altogether, approximately 1.6 million beneficiaries are enrolled in HMOs through risk contracts, cost contracts and other arrangements.

Beneficiary representatives supported the HMO provisions of the Tax Equity and Fiscal Responsibility Act of 1982 that created an incentive for HMOs to serve Medicare beneficiaries. We were optimistic about the possibility that HMOs would provide high quality care at a reasonable price. We were encouraged that our constituents might have access to preventive health care services that are currently not covered by Medicare. However, as we gain more experience with HMOs/CMPs we must revisit the program to insure we are adequately meeting beneficiary needs in terms of quality assurance, marketing practices, terminations, beneficiary information, and disclosure requirements.

For the past three years beneficiary representatives have monitored closely the growth and development of HMOs serving Medicare consumers. We have observed the maturation of HMOs as a key component in health care delivery, and as a provider of care to older Americans. In general, the program is functioning reasonably well. It is not a program, however, that can or should police itself. Through our consumer education programs about HMOs, we have learned first hand the many questions and confusions beneficiaries have about HMOs. We have noticed many areas where HMOs provide unclear, incomplete, and sometimes misleading information about their benefits and health care delivery system. We also have identified weaknesses that are not addressed by the current law and regulations.

HMO Quality of Care

The Congressional mandate for external quality of care reviews as expressed in DEFRA and reaffirmed in OBRA is necessary and is strongly supported by beneficiary representatives. The incentives inherent in prepaid health care to underserve HMO members coupled with the vulnerablity of older people who have enrolled in HMOs on an individual basis makes such review essential.

Most HMOs provide high quality health care. However, as Dr. Roper told an HMO audience in April, "even one quality of care problem is one too many." We agree!

However, HCFA's scope of work for HMO quality of care review does not assure beneficiaries that all symptoms of inadequate care will be identified.

There are acceptable elements in the scope of work. On the positive side, we are pleased that reviewers will examine a broad base of indicators for data on quality of care problems. We are pleased to see that inpatient care reviews are required to include the medical record for ambulatory care and, for certain conditions, post-hospital care. This requirement will permit the review organization to compile complete patient records for a variety of situations that may be indicative of inadequate or inappropriate care. We are encouraged to see that data collected through this review process will have the same confidentiality and disclosure requirements as other data collected by Peer Review Organizations.

Requiring each review organization to develop a beneficiary outreach program is a needed and well-founded component of the review program. Beneficiaries need to know where they can file a complaint against HMO, and to know about the nature and purpose of the HMO/CMP review program.

From our perspective there are serious flaws in the plan for focusing review activities, the sequence of activities required under the RFPs scope of work, and some omissions in the review categories.

First, we are distressed to learn that decisions about the level of medical record review will be based on the review organization's assessment of each HMO/CMP's internal quality assurance program rather than on an initial uniform and comprehensive review of medical outcomes in each HMO. This approach is not consistent with HCFA's methodology for reviews of hospital care under the prospective payment system or in keeping with Congress' intent that the review program emphasize patient outcome assessments. We have reviewed audit reports from several HMOs that were judged to have inadequate and ineffective quality assurance programs even though these programs met HCFA's standards at the time a risk contract was signed. Given this information plus the vagueness of review criteria in the scope of work, we do not have confidence that a structural review of

internal quality assurance program is sufficient to accurately evaluate the overall quality of care provided by an HMO or CMP.

Second, we are particularly disturbed that the scope of work focuses at the outset on a limited review if the HMO's quality assurance process is determined to be adequate. Regardless of the adequacy or inadequacy of an HMO's quality assurance program, we feel the initial review activities should concentrate on compiling uniform, comprehensive and comparable data on every HMO/CMP that is serving beneficiaries. We suggest, therefore, that every HMO and CMP should be included in the basic review protocol during the first year of the review contract. This is essential in order to establish a comprehensive baseline on all HMOs. We believe that defensible decisions about different review levels can and should be made only after comprehensive performance data has been compiled on all HMO's and CMPs for a year. This approach is, in our opinion, in keeping with Congress' intent for an HMO/CMP quality of care review program.

An approach that targets reviews based on HMO/CMP performance data is preferable. We indicated to HCFA and to the Office of Management and Budget that we support the development of a review program that directs more resources toward health plans that have quality of care problems than toward health plans that are providing high quality care. We are not confident, however, that the sequence of activities included in the scope of work will permit a reliable identification of good and bad HMOs and CMPs.

Third, we are disappointed that the scope of work does not clearly delineate activities that will yield data on access problems within an HMO/CMP. With the exception of requiring reviews of complaint files, the review protocol relies solely on medical records for data on quality, access, and appropriateness of care. We question whether this is adequate to capture information on barriers to care that prevent members from getting care at all. We believe a survey of HMO members who have not used any services during a calendar year period may yield useful information about access problems. We are also disappointed to learn that reviews of non-trauma hospital admissions through the emergency room have been eliminated from the review requirements. Analysis of this data would provide a useful indicator of access and quality problems.

We hope Congress and HCFA will work together with beneficiary representatives as the HMO quality review program is implemented and changes are made in the scope of its activities.

HMO/CMP Marketing and Enrollment Practices

We continue to receive complaints from throughout the nation regarding the marketing practices of HMOs. Of particular concern are membership enrollment procedures that serve as a screening device for prospective members who are not healthy. Enticing prospective members to dances, paying referral fees to residents in retirement communities for the names and addresses of their neighbors, permitting HMO enrollment only through an in-person visit to the HMO's office or medical center -- all of these practices can be viewed as an attempt to identify and enroll able-bodied, ambulatory Medicare beneficiaries and to screen-out individuals with health problems. The fact that these tactics can and are used in numerous HMOs throughout the nation is evidence that HCFA's review of an HMO's printed marketing materials and advertising campaigns is inadequate to identify HMO procedures that screen out less-healthy beneficiaries.

In addition, consumers have complained that some HMOs will not provide their list of providers or their membership rules for examination before a beneficiary joins the HMO.

Although HCFA has an obligation to regulate HMO marketing and enrollment practices, responsibility for monitoring appears to be shifted by default to state Insurance Departments or Attorney General's consumer protection divisions.

We urge HCFA to expand its enforcement activities regarding HMO/CMP marketing and enrollment practices. Specifically,

- HCFA should establish minimum standards for written marketing and membership materials. These standards should be developed in consultation with beneficiary representatives and language experts to determine how to reduce potential misunderstandings by clear and complete explanations of problem areas such as "lock-in", disenrollment, and access to services.

- In communities where English is not the primary language for more than 5% of the eligible population, HCFA should require HMOs/CMPs to provide written marketing materials that have been translated into relevant language.

- HCFA should require HMOs/CMPs to make its membership rules available for examination be prospective members in advance of joining.

Medicare Contract Terminations

When HMOs/CMPs terminate their contract with Medicare, enrollees involuntarily must make other arrangements for health insurance. As of the end of 1986, termination of 10 contracts required 23,650 beneficiaries to enroll in another HMO (an option in four communities), subscribe to Medicare supplemental insurance, or pay out-of-pocket the Medicare deductibles and co-payments plus the costs for services not covered by Medicare.

Federal regulations currently require HMOs/CMPs to give beneficiaries at least 60 days notice of contract termination. This amount of notice is insufficient for those beneficiaries who choose to subscribe to Medicare supplemental insurance because of the waiting periods for coverage of pre-existing conditions. The majority of Medicare supplemental policies have at least a 6-month exclusionary period for coverage of pre-existing conditions. Under current Medicare contract termination notification requirements it is impossible for enrollees with health problems to avoid a gap in coverage if their decision is to subscribe to Medicare supplemental insurance.

We recommend that contracts with Medicare should be amended to require HMOs/CMPs to pay enrollees' costs for treatment of Medicare-covered pre-existing conditions during the period between contract termination and the end of the supplemental insurance policy's exclusionary period for pre-existing conditions.

Coordinated Open Enrollment

Section 2350(a) of P.L. 98-369 (the Deficit Reduction Act) requires HCFA to establish, for geographic areas served by more than one HMO enrolling Medicare beneficiaries, a single 30-day period each year during which all HMOs must allow open enrollment. The statute permits a three year period to implement this requirement. HMOs have opposed this requirement, and to date we have not seen a draft regulation from HCFA.

We believe that the coordinated open enrollment requirements could help resolve some of the problems regarding coverage of pre-existing conditions encountered by beneficiaries when an HMO chooses to terminate its contract with Medicare. Given the fact that HCFA currently contracts with many HMOs on a calendar year basis, and intends to eventually have all HMOs with risk contracts on the same contract cycle, it appears that some of the operational problems cited by HMOs have been eliminated. We urge HCFA to proceed expeditiously in drafting a regulation to implement Section 2350(a) of P.L. 98-369.

Two-Tier Health Care Delivery Systems

Last fall Medicare members of one California HMO were notified that the HMO was terminating its contract with certain providers. Members who were receiving health care from these providers were told that they would have to receive care from different physicians and use different medical centers. These members subsequently learned that the HMO's employer-sponsored groups were permitted to continue getting care from the original provider groups.

While we do not believe this practice of two-tier health care delivery is common among HMOs with Medicare contracts, even one instance is troubling. Long-standing members of this particular HMO were forced to change physicians and use medical facilities that were not as close to their homes. The change has also caused confusion and hostility among HMO members.

HMOs should not be permitted to deny access to certain providers for their Medicare members while permitting their

commercial members to continue getting care. We suggest that HCFA amend their Medicare contracts to explicitly preclude this practice.

Premium Increases/Financial Disclosure

Since 1985, many HMOs with Medicare contracts have sharply increased their premiums, added member copayments for office visits, and eliminated such benefits as prescription drug coverage. The effect of these premium increases and benefit changes do not appear to be extreme when considering aggregate data on all HMO risk contracts from the Office of Prepaid Health Care. However, an analysis of changes in premium and benefits within zero-premium and low-premium HMOs that have contracted with Medicare since mid-to-late-1985 shows the economic effects on their Medicare members are to be far more serious.

As of December 13, 1985, 16 of 90 HMO risk contracts charged no premium. A year later, three of these HMOs had cancelled their contract with Medicare, and four had added premiums ranging from $21.38 to $40.00.

Sharp increases in premiums and out-of-pocket expenses were enacted by the vast majority of HMOs charging a premium at or below $15.00 in late 1985. As of December 13, 1985, thirteen HMOs charged premiums between $2.09 and $15.00. By the end of 1986, only two of these HMOs held their premium constant. One HMO increased its premium by 33%; premium increases for the other ten HMOs ranged from 95% to as much 809%.

In addition to these dramatic increases in premiums many of these HMOs changed their benefit package. Two plans dropped their prescription drug coverage, two added a copayment for physician services, one plan eliminated its high option package, and three plans eliminated coverage for preventive care.

Perhaps these price increases are justified. However, beneficiary representatives has been unsuccessful in efforts to determine whether these premium increases and benefit changes are reasonable based on the HMO's cost for serving Medicare beneficiaries. HCFA's requirements for HMO financial reporting

focus on financial solvency; data on profit and loss is considered proprietary information and is not available to outside observers.

HMOs may be pricing their Medicare benefits packages low during the first year or so of their contract in order to attract enrollees, and then increase premiums substantially after they have a captive market. This practice should not be tolerated or condoned. More is at stake for beneficiaries than simply the amount spent each month for HMO premiums. For beneficiaries who cannot afford a premium increase of $15 - $30/month, resubscribing to their previous Medicare supplemental insurance policy may not be simple or even possible. Many supplemental policies will not permit resubscription after a policy has been dropped. Many employers will not reinstate coverage in their retiree health benefits program if the retiree voluntarily dropped out to join a low-cost HMO. Virtually all Medicare supplemental insurance policies have a waiting period for pre-existing conditions that would cause a gap in coverage.

We urge Congress to closely examine the extent to which premiums have increased over time for Medicare beneficiaries in HMOs. In addition, we request that Congress consider a ceiling on annual premium increases for Medicare benefits packages.

Consumer Information

Prospective HMO members need at least a description of benefits, health care delivery system, and the costs of membership. In addition, information about HMO/CMP administration and operation, costs and financing, and quality is necessary. Consumers should be able to identify whether the HMO is a publicly-held corporation, a private investor-owned corporation, or a non-profit corporation. Information should be available about the HMO/CMP's structure (i.e., staff, group, network or IPA-model health plan), and the nature of its subcontracts for specialty care, home health services, hospice care, and other support services. Information should indicate which department in the HMO is responsible for controlling payment for subcontracted services. Prospective members should also be able to receive complete information about enrollment and

disenrollment practices and the amount of time required to complete both of these procedures.

We urge the Health Care Financing Administration to allocate federal funds for the development of local or regional consumer information programs about capitated health plans. The Association urges HCFA to develop specifications for a uniform health service information data base. In areas where HMOs/CMPs are serving Medicare beneficiaries, HCFA should contract with consumer groups or Agencies on Aging for the compilation and dissemination of consumer information.

HMO Staffing

HMOs traditionally have provided health care to employer-sponsored groups of working people. HMOs/CMPs are not required to hire staff with training in geriatric medicine, or to provide in-service needs of older patients. Federal law and regulations do not require an HMO/CMP to designate staff or telephone lines expressly to serve their Medicare members.

Regulations pertaining to Medicare certification of HMOs/CMPs should require health plans to tailor their health system to meet the needs of older patients. We realize the application of this requirement will vary depending on the structure of an HMO/CMP. At minimum, HMOs/CMPs should be required to hire case managers with special training in the medical and social service needs of older patients. At minimum, the HMO/CMP should provide in-service training about the aging process for medical and support staff who will be serving Medicare beneficiaries. HMOs/CMPs should be required to hire medical staff with specialty training in geriatric medicine, or have such expertise available for consultation. Capitated health plans should be required to provide an office or ombudsman specifically responsible for resolving problems of Medicare beneficiaries.

Conclusion

Beneficiary representatives call upon Congress to enact the following changes in federal law and regulations pertaining to HMOs and Medicare:

- Require uniform and comprehensive reviews of HMOs during the first year of the quality review program. Target reviews only after all HMOs have been reviewed uniformly. Increase review activities to identify access to care problems.

- Strengthen oversight of HMO marketing practices.

- Revise contracts between HCFA and HMOs to require HMO to pay member's costs for treatment of Medicare-covered pre-existing conditions during period between contract termination and end of supplemental insurance policy's waiting period for pre-existing conditions.

- Require implementation of regulation on coordinated open enrollment in areas where there is more than one HMO with a Medicare contract.

- Add language to HMO/Medicare contracts prohibiting decisions to deny access to certain providers for Medicare beneficiaries while maintaining access to these providers for other subscriber groups.

- Require realistic pricing of benefits package for Medicare beneficiaries.

- Require HCFA to allocate federal funds for local or regional HMO consumer information programs.

Mr. MICA. Thank you very much, Ms. Skinner, and I gather you came quite a distance to be with us today. We thank you very much.

I'd like to just comment, I've been looking at prescreening practices and it totally eluded me that they invite them to dances to see if they're healthy enough to dance. We had one in Florida where they invite them to chicken dinners. I'm wondering now if they were looking at their teeth. You just don't know.

Mr. Robert Crane, Vice President of the Kaiser Foundation, Oakland, California. Another one who came a long distance to help us today. Please proceed.

TESTIMONY OF ROBERT CRANE, VICE PRESIDENT, KAISER FOUNDATION HEALTH PLAN, OAKLAND, CA

Mr. CRANE. Thank you very much, Mr. Chairman. As noted, I am Robert M. Crane, vice president, Government Relations, of Kaiser Foundation Health Plan Inc. I bring the regrets of Robert Erickson who had planned to be with you today to testify and was not able to do so.

Kaiser Foundation Health Plan, its 11 subsidiaries, Kaiser Foundation Hospitals and 12 independent medical groups comprise the Kaiser Permanente Medical Care Program. The program provides health services on a prepaid, direct service basis to over 5 million members in 16 States and the District of Columbia. We have been serving medicare beneficiaries since medicare's inception. Since that time, our Medicare membership has grown to over 335,000, or 7 percent of our total enrollment. Many of these medicare beneficiaries have been health plan members through much of their working lives and have chosen to continue their health plan membership in retirement. Nine of our 12 regions have signed medicare risk contracts. The 10, southern California, hopes to have one signed by the end of this month.

We believe that the fundamental concept set forth in the risk contract legislation is sound and extremely important to maintain. We, like the Members of Congress, have been concerned with the activities of certain risk contractors, particularly with situations in south Florida that has been discussed today.

At the same time, we believe the situation is not typical of the manner in which the program operates across the Nation. While action is required, overreaction would be counterproductive. There are important adjustments in the program that need to be made to attract and retain quality organizations to the risk contract program.

Continued and improved oversight is also necessary. More specifically, we recommend the following:

First, improve the adjusted average per capita cost—AAPCC—methodology. The current AAPCC methodology does not adequately explain or compensate for beneficiary risk. It is important that Congress and HCFA place high priority on improving it.

Second, promote understanding of and stability in the HMO payment methodology. There is a need to assure that the rules of the game of payment are understood and stable over time. The AAPCC methodology should be set forth in regulations so that the factors,

assumptions and details in the methodology are understood by all. Accomplishing this may require statutory change.

Third, insist upon strict application of the 50/50 rule. We believe that only HMOs or CMPs that are attractive to the population at large should be offered to medicare beneficiaries.

The percentage of medicare/medicaid enrollment in a participating HMO should exceed 50 percent only in rare and carefully monitored instances.

Fourth, assure adequate HCFA oversight of plan operations. We would urge a review of HCFA staffing levels to assure that staff is adequate to perform the monitoring responsibilities of the growing number of risk contractors.

Fifth, evaluate and refine the quality assurance mechanisms. The methodology that will be employed under PRO review has never been tested. It is important that it be carefully evaluated as it is implemented. Because the state of the art of reviewing quality in HMOs is still in its infancy, it is important to encourage diversity in approaches to this task. It is also important that external review not be designed and implemented in a way that stifles innovation in internal quality assurance programs.

We believe that the long term prospects for medicare HMOs are good. Working together, the government and the industry can solve the issues that I have raised. A growing number of our elderly citizens can and should have an HMO option. However, capitation is not a panacea, but should be seen as one alternative for paying for care of the Nation's medicare beneficiaries.

Thank you, Mr. Chairman.

Mr. MICA. Thank you, Mr. Crane. Let me just say on your testimony we'll come back with questions. I'm extremely interested in your methodology points and if Kaiser has done any studies that could be helpful to this committee regarding that, we'd love to have them.

Our next witness is Kathryn Langwell, Senior Economist of Mathematica Policy Research here in Washington.

Please proceed.

[The prepared statement of Mr. Erickson follows:]

PREPARED STATEMENT OF ROBERT J. ERICKSON, SENIOR VICE PRESIDENT

AND GENERAL COUNSEL, KAISER FOUNDATION HEALTH PLAN, INC.

Mr. Chairman and members of the Committee, I am Robert J. Erickson, Senior Vice President and General Counsel of Kaiser Foundation Health Plan, Inc. I am accompanied by Robert M. Crane, Vice President - Government Relations.

Kaiser Foundation Health Plan, Inc., its eleven subsidiaries, Kaiser Foundation Hospitals and twelve independent Permanente Medical Groups comprise the Kaiser Permanente Medical Care Program. The Program is an economically self-sustaining organized health care delivery system that provides health services on a prepaid, direct service basis to over 5 million members in California, Oregon, Washington, Hawaii, Ohio, Colorado, Texas, Maryland, Virginia, Connecticut, New York, North Carolina, Georgia, Kansas, Missouri, Massachusetts, and the District of Columbia. Our Health Plan members receive services through 28 of our own hospitals, more than 140 medical office locations, more than 5,900 contracting physicians and over 50,000 employees.

Kaiser Foundation Health Plan, Inc. has been serving Medicare beneficiaries since Medicare's inception. When enacted in 1965, Medicare did not contain provisions to pay group practice prepayment plans (one of the HMO prototypes) on a basis consistent with the way in which they were paid for non-Medicare members. Instead, hospitals which served group practice prepayment plan members were paid under Part A on the same basis as other hospitals and such plans were paid for Part B services on a per capita basis which was cost-based. The only other option was to submit bills and be paid on a fee-for-service basis. Since that time, our Medicare membership has grown to over 335,000 or seven percent of our total enrollment. Many of these Medicare beneficiaries have been Health Plan members through much of their working lives and have chosen to continue their Health Plan membership in retirement.

Kaiser Permanente is committed to serving the Medicare population and expects it to be a growing percentage of our business in the years ahead. It is because of this commitment that since the early 1960's, we have advocated that Medicare adopt a method of payment for prepaid group practice plans and other HMOs that is consistent with the manner in which they are paid for non-Medicare members.

It was not until two decades later with the passage of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 that this goal was realized. The risk contract program established by this legislation was designed to benefit each of the participants. The federal government saves five percent by paying the HMO 95 percent of the adjusted average per capita cost (AAPCC). The HMO receives its adjusted community rate (ACR), the rate for providing Medicare A and B benefits to Medicare beneficiaries adjusted for expected Medicare utilization. The beneficiary receives a benefit from selecting the HMO in the form of increased benefits or reduced costs that result from the HMOs more efficient operation.

Kaiser Permanente participated in the demonstration effort that showed that this system of payment for HMOs would work. In 1978 our Northwest Region, headquartered in Portland, Oregon, became one of seven Medicare demonstration contractors to test the feasibility of increasing enrollment of Medicare beneficiaries in HMOs. This effort demonstrated the ability to attract a representative age and geographic cross section of the senior citizen population. Enrollment of new Medicare members into Kaiser Permanente in Portland increased the percentage of over 65 members enrolled in our plan from 6.85 percent in 1979 to 11.9 percent today which is the same percentage as those 65 and over in the Portland community. Patient surveys showed a high level of satisfaction, a low annual cancellation rate, and indicated excellent member acceptance.

With the implementation of the risk contract program in 1985, a number of our other Regions have signed risk contracts and begun to participate. Nine of the Program's 12 Regions have entered into Medicare risk contracts. A 10th Region, Southern California, hopes to have a contract signed by the end of this month. At the

end of 1986, Medicare risk contract enrollment was over 30,000 or approximately 10 percent of total Medicare membership (334,530). Now that we are able to offer the Medicare risk program to existing Medicare cost members without the 2-for-1 limitation, we expect our risk contract membership to increase several fold before the end of the year.

Medicare members have been fully integrated into the Kaiser Permanente Program. In addition to receiving Medicare A and B benefits, risk beneficiaries receive preventive services, such as routine physical examinations, examinations for hearing and vision and most immunizations and have no deductibles and no or modest copayment amounts. Six of our contracts provide risk beneficiaries with an outpatient drug benefit, two provide eyeglasses as a benefit and one includes hearing aids. Our recent surveys and disenrollment figures indicate an ongoing high level of satisfaction among these members. Recent surveys in Oregon showed that only 1.3 percent of the Medicare members expressed any dissatisfaction with the plan.

However, statistics only tell part of the story. It is also important to emphasize the human side of the provision of services to Medicare beneficiaries under a risk contract. Consider the elderly couple who arrives at our medical offices for an initial visit with a shopping bag full of drugs prescribed by different community physicians. The value of coordinated and managed care for these individuals which starts with a complete physical and pharmaceutical assessment cannot be underestimated. Or consider the 80 year old woman with a multitude of chronic health problems who for the first time visits a physician without worrying about the financial consequences. These examples are just several of thousands that could be described to underscore the fact that Medicare beneficiaries continue to benefit significantly from enrollment under the risk contract program with group practice payment plans and other HMOs.

While there is a general level of satisfaction with the risk contracting program within Kaiser Permanente, we have significant concerns with events occurring outside our Program. Of major concern is the situation which has developed with International Medical Centers (IMC) in South Florida. Whenever there are problems of this nature within an industry, the industry as a whole suffers. We learned this from the prepaid health plan scandals in California in the early 1970's. We are seeing this repeated in South Florida in the 1980's. However, unlike past crises where the absence of rules led to abuse, the IMC situation underscores the need for more vigorous monitoring of problem HMOs or CMPs and more decisive action when current rules are not followed. For example, the rule requiring that 50 percent of a participating plan's enrollees be persons who are not covered by Medicare or Medicaid should be waived only in very unusual situations.

There are deficiencies in the Medicare risk contract program. Many HMOs are concerned about the level and stability of payment over time. Year-to-year fluctuations in the AAPCC at the county level are making planning difficult. Concern about payment adequacy has already led several risk contractors to decide not to renew contracts. Indications are that the number of such HMOs will increase unless there are improvements in the payment methodology. In addition, some plans are concerned that the new Quality Review of risk contractors may not recognize the differences in HMO medical practice styles and may be unnecessarily complicated. This may create barriers to HMO participation in the Medicare risk contract program.

However, our assessment of the current situation is that a major overhall of the risk contract program is not necessary and would be counter-productive. Rather continued fine tuning is needed combined with continued and improved administrative oversight. More specifically, we see the following as necessary:

1. Improve the adjusted average per capita cost (AAPCC) methodology.

The AAPCC represents the fee-for-service equivalent of providing care to non-HMO enrolled Medicare beneficiaries in a geographic area. While this methodology appeared adequate to begin the program, it is increasingly clear that the age, sex, welfare and institutional factors included in the AAPCC do not adequately explain or compensate for beneficiary risk. It is important that Congress and HCFA place high priority on improving this methodology. To accomplish this, efforts should be

undertaken to advance the "state of the art" so that HMOs will have the assurance that participating in this program will provide fair reimbursement. This is necessary to assure government savings, HMOs continued participation, and that the member is properly rewarded for selecting a prepaid plan. There are a number of risk adjustment methodologies that deserve more critical evaluation and demonstration. These involve direct measures of health status, such as perceived health status measures and functional health status measures, as well as indirect measures such as prior health care use. We are actively working on this issue through our Center for Health Research in Portland. They were awarded a three-year cooperative agreement by the Health Care Financing Administration in late 1985 to develop risk adjustors based on plan ambulatory and inpatient data. The project will relate use of health services by Medicare beneficiaries, to patterns of morbidity, perceived health status, self-reported chronic conditions and cause-specific mortality.

2. Promote understanding of and stability in the HMO payment methodology.

There is a need to assure that the "rules of the game" are understood and stable over time. This includes both payment and operational requirements. Currently, the details of the methodology for developing the AAPCC are not set forth in regulations. This leads to two problems.

First, the factors, assumptions, and methodology for its development are not well known or understood across the industry. This "black box" approach leads to much uncertainty about what may happen to payments in the future. Second, changes can now be made in the method or factors without public disclosure. We recommend that Congress adopt a requirement that the AAPCC methodology be set forth in regulations and that any changes in it follow the rule making process. Since a number of the factors represent assumptions about the future, it is important that these be exposed to scrutiny. The methodology should not be mysterious. We suggest a process similar to the publication of the rules relating to the perspective payment methodology for hospitals be followed for the AAPCC. Accomplishing this may require statutory change.

3. Insist upon strict application of the 50/50 rule.

Current law requires that Medicare and Medicaid enrollment not exceed 50 percent of a plan's total enrollment except in rare instances. This rule was established so that HMOs and CMPs would have to meet a market test. They would have to be organized and operated in ways that are attractive to employers and the community at large in order to serve a sizeable non-Medicare, non-Medicaid enrollment. This requirement adds a strong measure of market regulation to the risk contract program. We have learned from the IMC situation, and earlier, in the Southern California prepaid health plan scandals, that not following this rule frequently causes problems. We believe that if the HMO or CMP is not attractive to the population at large, it should not be offered to Medicare beneficiaries, except in rare instances such as those authorized in last year's budget Reconciliation Act (PL 99-509).

4. Assure adequate HCFA oversight of plan operations.

The number of risk contractors has increased dramatically over the last two years. There has not been a comparable increase in HCFA's management staff at either the Regional or Central Office level to oversee these operations. Adequate HCFA staff resources are particularly needed in dealing with problem HMOs or CMPs. We would urge a review of HCFA's staffing levels to assure that the staff is adequate to perform this important function.

5. Evaluate and refine the quality assurance mechanism.

Beginning this year, Professional Review Organizations (PROs) or quality review organizations will begin evaluating the quality of care in HMOs. We strongly support quality assurance activities in HMOs and efforts monitoring those activities. We also recognize the legitimate interest of government and others in external review and that such review, properly structured, can be salutary. We do have concern about the methodology that will be employed under the PRO review. It is structured on the review model which PROs have used to monitor utilization within hospitals and it was not tested prior to national implementation. It is

data intensive and emphasizes outside oversight at the expense of incentives for the development of strong internal quality assurance programs.

We believe that the best assurance of quality of care is a commitment of an HMO or CMP to that goal. We have spent considerable effort to develop effective quality assurance programs for both inpatient and outpatient settings. We are concerned that the resources and effort that will be required to comply with the proposed PRO review may stifle innovation in quality assurance and may lead to a decreased emphasis on internal activities. Congress should carefully monitor the evolution of this process and require structured evaluation of whether the methodology employed is having its desired affect. At the same time, it should encourage alternative approaches in this extremely important area.

Mr. Chairman, to conclude, we believe that the fundamental concept of a risk contract is sound and extremely important to maintain. The situation that developed in South Florida is not typical of the manner in which this program operates across the nation. The fact that this can happen requires action, but hopefully will not result in overreaction. There are important adjustments in the program that need to be made and continued oversight is necessary. We believe that the long term prospects for Medicare HMOs are good if the issues we have discussed can be solved. A growing number of our elderly citizens can and should have an HMO option. However, capitation is not a panacea, and we believe that significant fee-for-service option will need to continue to exist.

Mr. Chairman, we stand ready to assist Congress and the Administration with modifications of the risk contract program so that a significant number of our senior citizens have the option of joining a prepaid group practice or other HMO of good value and sound quality.

TESTIMONY OF KATHRYN M. LANGWELL, SENIOR ECONOMIST AND PROJECT DIRECTOR, MEDICARE COMPETITION DEMONSTRATION EVALUATION, MATHEMATICA POLICY RESEARCH, INC., WASHINGTON, DC

Ms. LANGWELL. Thank you, Mr. Chairman.

I have spent much of the last 10 years studying the nature and extent of competition in the health care market, and the impact of changing financial arrangements on consumers, providers and third party payers.

Capitation payments and HMOs have been widely promoted for a number of years as a potentially valuable means for achieving some degree of cost constraint in this market where the consumer doesn't pay the full price of services and where tax treatment of health insurance encourages first dollar coverage.

My research and participation in policy discussions around the country leads me to believe that capitation, case management and increased competition offer hope for achieving cost containment and improving financial access to care for beneficiaries in public programs.

As preparation for this hearing, I devoted considerable time to reviewing what knowledge we have at present on the effects of the medicare HMO program. Because of dramatic changes in the HMO industry in recent years, and because medicare beneficiaries are a distinctly different group from the employed under-65 population served by HMOs in the past, there is little previous research to draw upon for reliable results. However, I think we do know quite a bit already about the program.

First, with respect to impacts on medicare beneficiaries, our research has shown that during the demonstration program, approximately 5 percent of medicare beneficiaries joined an HMO when it became an available option. While less than 2 percent of high-income beneficiaries with existing medigap insurance joined, over 20 percent of low income medicare beneficiaries, who weren't medicaid eligible and who did not previously have medigap coverage, elected to join an HMO. The medicare HMO program clearly has the potential to benefit medicare beneficiaries who currently face considerable financial barriers to health care.

We also know that medicare beneficiaries who join HMOs were much less satisfied with the aspects of the care they were receiving from the fee for service system before joining the HMO. Medicare HMOs offer an alternative delivery system that may improve these beneficiaries' overall satisfaction with their health care arrangement.

With respect to short run and long run financial implications for the medicare program, we don't yet have that information. Mathematica's evaluation will provide results on the nature, extent, and the underlying causes of biased selection into 17 demonstration HMOs and will produce firm evidence for the first time on the impact of HMOs on use and cost of health services to Medicare beneficiaries.

I understand there is much dissatisfaction with the AAPCC methodology. But I strongly recommend that no changes in the

methodology be made before these results are available in mid-1988 and have been carefully considered.

Turning to the implementation experience and the ongoing management of the medicare HMO program, there clearly have been startup problems, as is to be expected in any new program that grows much more rapidly than originally was expected. In general, these problems have been recognized by HCFA, the HMO industry and by Congress, and many of them have been and are being addressed.

The first demonstration HMOs chose to proceed fairly cautiously in the program at the beginning, setting medicare enrollment targets and preferring to evaluate their initial experience with the medicare population before expanding medicare enrollments further. In that sense, the IMC situation is an aberration among the early HMOs in this market.

My observations and those of others suggest that the program could operate somewhat more smoothly for beneficiaries if information dissemination was improved. Particularly, the relatively high disenrollment rates that we've observed in the first few months after enrollment suggest that some beneficiaries need more information or better presented information on the HMO option.

Similarly, more information on appeals processes and perhaps some system of assisting medicare beneficiaries to implement that complex process could be helpful to beneficiaries. Some mechanism for assisting beneficiaries to obtain medicap coverage when they leave the HMO would be a useful addition to the program, particularly since, in our surveys, we have observed that one third of those who were previously insured before joining the HMO are continuing to pay for that insurance a year or more after joining.

Quality assurance is certainly a significant issue for medicare beneficiaries regardless of whether they obtain care from fee for service providers or from HMOs. But since the HMO program is still new, it is particularly important that beneficiaries be able to join HMOs that have been required to meet standards for internal review and that are subject to external review of quality of care.

Our studies in the quality assurance programs in medicare HMOs, the initial demonstration ones, shows that what some HMOs say they have in place as quality assurance programs aren't actually operating effectively, and in some cases aren't operating at all. This is a minority of HMO's but it means that the PRO system certainly can't rely just on what the HMOs are reporting as operational quality assurance programs to decide whether more intensive review is required.

I'd like to conclude by saying that beneficiaries certainly seem to be responsive to the program, as is the HMO industry. For the program to continue to grow and result in benefits to beneficiaries and the government, changes should be undertaken as part of a comprehensive reexamination of the program. A piecemeal approach to changes may undermine this new program before it has sufficient time to become a well understood option that medicare beneficiaries can choose in order to improve their access to care or because they prefer a case managed style of health care delivery.

Thank you.

[The prepared statement of Ms. Langwell follows:]

KATHRYN M. LANGWELL, SENIOR ECONOMIST, MATHEMATICA POLICY RESEARCH, WASHINGTON, DC

During the past decade, I have been continuously involved in research on the market for health services. The effects of competition on health care costs and the role of HMOs in changing the competitive environment has been of particular interest to me, beginning with my participation in the American Medical Association's National Commission on the Cost of Medical Care and continuing through over a dozen research studies and my current position at Mathematica Policy Research as Project Director for the National Evaluation of the Medicare Competition Demonstrations being conducted for the Health Care Financing Administration. My participation in this hearing is as a researcher with extensive experience in examining the structure and performance of the market for health services and the effects of increasing competition in that market, principally through the development and expansion of HMOs and other alternative financing and delivery mechanisms. I would like to emphasize that my testimony represents only my own views and not those of Mathematica Policy Research or of the Health Care Financing Administration. While I draw upon results of completed research from the Evaluation of the Medicare Competition Demonstration to address issues, work that is currently underway is not discussed except to mention that these future results may be very useful in ongoing policy deliberations.

Based upon the existing evidence, I believe that capitation arrangements and case management offer the best hope for improving financial access to appropriate quality health services for beneficiaries covered by public programs, within an environment that requires cost constraint. The unexpectedly rapid growth of the Medicare HMO program suggests that Medicare beneficiaries are responding to the opportunity to improve their benefits and reduce their financial liabilities for health care. The substantial participation of HMOs in the program (over 25 percent of all HMOs) indicates that the HMO industry, also, believes that this is a viable option -- at least under current terms. Whether the program saves money for the Government in the short-run is unclear; however, the longer-run effects on the Medicare market may be sufficiently desirable that some level of short-run costs may be warranted.

While the implementation of the TEFRA HMO program has not been uneventful, it's reasonable to expect that any new program will encounter unanticipated situations during its early years and that procedures will work smoothly only after some experience has been gained. With two years of operational experience to draw upon, this is a good time to review that

experience and determine whether additional changes would result in a more smoothly operating program.

In this paper, I have focused on three issues that, in my opinion, are critical for evaluating the performance of the Medicare HMO program and other future capitation initiatives:

1. Do Medicare beneficiaries benefit from the program?
   -- Is financial access to care improved?
   -- Does having choices increase the availability to Medicare beneficiaries of satisfactory health care arrangements?
   -- Is quality of care maintained?
   -- Is there an effect on continuity of care and financial vulnerability?
2. Does the Medicare HMO program save money?
   -- Is biased selection an issue?
   -- To what extent do HMOs save money through case management, negotiated discounts, physician incentive arrangements, and other mechanisms?
   -- If most HMOs generate surpluses greater than 5 percent plus "profit", should the Medicare program -- rather than Medicare beneficiaries only -- obtain greater financial benefit from these savings?
   -- What are the competitive effects of Medicare HMOs and do they suggest potential longer-run benefits from the programs?
3. Is the Medicare HMO program operationally feasible?

We don't have the full answers to all these questions yet, but the evidence on many of these issues is beginning to become available. I'd like to briefly review, in this paper, what we do know about these issues and what we will know soon as current research in progress is completed.

IMPACT ON MEDICARE BENEFICIARIES

Financial Access

The Medicare program pays 75 percent of all Medicare-covered health care expenditures and 48 percent of total health care costs incurred by beneficiaries.[1] To avoid incurring substantial liability for out-of-pocket costs, over 70 percent of Medicare beneficiaries purchase supplemental insurance. MPR's survey of Medicare beneficiaries enrolled in HMOs found that expectations of lower out-of-pocket costs of obtaining health services was the primary reason for enrolling in an HMO for over half of respondents; another 20 percent indicated that the expanded benefits available through the HMO were the primary reason they enrolled (Brown et al 1986). Table 1 summarizes the expanded benefits offered by TEFRA HMOs a year after implementation of the program. These benefits are provided, in most HMOs, with only minimal cost sharing and no deductible. Over 85

[1]Medicare does not pay for preventive care, prescription drugs, routine vision and hearing services, or most long term care. Consequently, Medicare beneficiaries total out-of-pocket liability in 1984 was $1,546 or 14.6 percent of income (Lave, 1986).

percent of these HMOs charged a premium of less than $38 per month in 1985. CBO has estimated that the average monthly premium for a medigap policy in 1988 will be $49.80, for a benefit package that is less generous than that offered by most HMOs.

TABLE 1

Percent of TEFRA[1] risk plans offering expanded benefits as part of either a basic or high option plan: United States, March 31, 1986

Benefit	Percent of plans offering benefit
Extended hospital days	79
Extended skilled nursing facility days	41
Preventive care	86
Drugs	71
Eye care	69
Ear care	37
Dental care	14
Extended mental health care	34
Other additional benefits	34

[1]Tax Equity and Fiscal Responsibility Act of 1982.

NOTE: "Expanded" benefits mean benefits that are beyond those normally covered by standard Medicare.

SOURCE: Office of Prepaid Operations: Prepaid Contract Status Report, March 31, 1986.

A recent study of enrollees in Medicare HMOs also suggests that financial access to care is improved particularly for beneficiaries who are most likely to be unable to afford health care (Brown and Langwell, 1987). Beneficiaries who are poor but not Medicaid eligible, who do not have Medicare supplemental coverage, and who do not have a regular source of care were found to be four times more likely to join a Medicare HMO than were other beneficiaries.

The evidence suggests that some Medicare beneficiaries may have improved financial access to care as a result of the Medicare HMO program. Whether the improvement in financial access leads to increased utilization of health services, however, has not yet been demonstrated. The recent Rand study of access to care for low income beneficiaries in one HMO indicates that some Medicaid beneficiaries encountered barriers to access within the HMO that were difficult for them to surmount. A study being conducted by Medical College of Virginia under Mathematica Policy Research's evaluation contract is examining beneficiaries' experience with HMO access barriers, based upon interviews with enrollees reporting symptoms and the response of the HMO to the enrollee's attempt to obtain services. Results of this study are expected to be available in early 1988.

Satisfaction

Those Medicare beneficiaries who join HMOs are significantly less likely to have had a regular physician before joining the HMO and, if they did have a regular source of care were significantly more likely to report dissatisfaction with aspects of fee-for-service care, including:

- professional competence
- willingness to discuss
- courtesy
- emergency care
- difficulty of filing Medicare and insurance claims
- costs

Overall, only 69 percent of enrollees reported that they had been satisfied with their previous fee-for-service source of care compared with 86 percent of Medicare beneficiaries who did not enroll (Brown and Langwell 1986). The availability of the Medicare HMO option offered these less satisfied Medicare beneficiaries an alternative financing and delivery system that may result in an increase in their overall level of satisfaction with care. Mathematica Policy Research and Medical College of Virginia are analyzing enrollee and nonenrollee interview data to determine the effect of HMO enrollment on satisfaction, overall and by type of satisfaction. Results of this study will be available in the Fall of 1987.

Quality of Care

Ensuring quality of care is an important issue in all health care policy deliberations. This is especially a concern when health policy changes are expected to affect highly vulnerable population groups. The concerns about quality under capitation arrangements is appropriate since the financial incentives of capitation could distort practice decisions of physicians. However, concern about quality should be equally great under fee-for-service arrangements. Physicians who face financial incentives to provide more than the optimal care may increase Medicare beneficiaries' exposure to iatrogenic illness and nosocomial infections,[1] as well as increasing out-of-pocket burdens on beneficiaries and costs to the Medicare program.

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[1]Haley et al (1985) estimate that 5.7 percent of hospital admissions develop nosocomial infections. If Medicare beneficiaries are no more vulnerable to nosocomial infections than the under 65 population, this infection rate suggests that 274,000 of the 4,799,000 hospitalized Medicare beneficiaries developed nosocomial infections in 1984.

Most of the physicians providing care to Medicare beneficiaries enrolled in Medicare HMOs are fee-for-service providers, also. In fact, in the Medicare Competition Demonstrations, 23 percent of enrolled beneficiaries surveyed had joined the HMO without changing their primary physician. It seems unlikely that fee-for-service physicians will choose to provide distinctly lower quality services to their HMO patients than to their fee-for-service patients.

The critical question is whether Medicare beneficiaries are receiving care of appropriate quality whether they obtain care from fee-for-service providers or from HMOs and other capitated arrangements. Practice patterns vary enormously around the country without necessarily implying that quality of care is better or worse in high use areas than in low use areas. In fact, the desirability of capitation rests on the assumptions that:

1. There are variations in practice patterns of physicians that are the result of custom or uncertainty rather than quality differences.
2. Existing practice patterns can change if physicians are better informed, administrative rules are put in place, and/or economic incentives are offered.
3. Physicians respond to administrative rules and economic incentives, but do not respond so strongly that quality of care is diminished.

Ideally, Medicare HMOs would enhance quality of care by providing case management that ensures coordination of services and reduces provision of unnecessary services that may be associated with iatrogenic illness and nosocomial infections. Provision of preventive services and reductions in financial barriers to access should also improve the overall quality of care to enrollees — especially for those with low income, without Medicare supplemental insurance, and with no regular source of care prior to joining the Medicare HMO.[1]

Having cited the potential quality advantages of Medicare HMOs and expressed my view that quality concerns are equally appropriate for fee-for-service reimbursed care, I will add that since the Medicare HMO program is new, it warrants special attention to ensure that all Medicare beneficiaries who are interested in the program can join an HMO that is meeting established standards for monitoring and responding to quality of care concerns and that is subject to independent, external quality review.

As part of the Evaluation of the Medicare Competition Demonstration, the Medical College of Virginia is conducting a study of the quality of the

[1] In the interview sample for the Evaluation of the Medicare Competition Demonstrations, 23.5 percent of Medicare HMO enrollees said that they did not previously have a regular source of care.

process of care in eight Medicare HMOs for basic care, including diabetes and hypertension management, colo-rectal cancer, and congestive heart failure. Data are being collected from HMO medical records and from fee-for-service providers' medical records in the same market areas. The results of the analysis, which will be available in Spring 1988, will provide evidence, for the first time, on the comparability of care provided to Medicare beneficiaries in Medicare HMOs with the care available to them in the fee-for-service sector in their own communities.

Continuity of Care and Financial Coverage

Unlike the employed population that must ordinarily make one decision annually about their health insurance arrangements and then be "locked in" until the next year, Medicare beneficiaries can move into and out of Medicare HMOs with notice only days or weeks in advance. This freedom to enroll and disenroll provides beneficiaries an opportunity to try out the HMO and, if they dislike aspects of the system or care provided, to resume their previous health care arrangements. The disenrollment provisions of the Medicare HMO program provide a "safety valve" for beneficiaries and for the Medicare program.

Although annual disenrollment rates from Medicare HMOs appear high,[1] there are no comparable data for other population groups since open disenrollment isn't an available option. It's also useful to point out that among the disenrollees surveyed in the first half of 1985 by Mathematica Policy Research, 26 percent had disenrolled in order to join another Medicare HMO.

The recent study of 1984 and 1985 disenrollment from Medicare demonstration HMOs (Brown et al. 1986) reported that:

- A relatively high proportion of Medicare beneficiaries (45 percent) disenrolled in the initial three months after enrollment. This pattern suggests that HMOs were failing to adequately inform potential enrollees of the "lock-in" feature of the plan and other aspects of HMO practice that may be unappealing to some beneficiaries. It is also possible that disenrollment in the first month may reflect high pressure marketing practices that persuade beneficiaries to join who then, on reflecting, decide to cancel their enrollment.

- Beneficiaries who appear more likely to be high users of services (e.g. older, reporting a health problem) were more likely to disenroll and this pattern appears to be consistent across plans and markets. High users have more encounters with the HMO delivery system and, therefore, may more quickly identify areas of dissatisfaction. Those beneficiaries who have "tastes" for high use — irrespective of health status — may resist case management pressures. In addition, this finding suggests that disenrollments may lead to a more favorable selection in HMOs.

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[1]Brown et al. (1986) found a 22.9 percent disenrollment rate among beneficiaries, who enrolled in 17 of the demonstration HMOs between January 1984 and January 1985, over the 12 month period following their date of enrollment.

- Disenrollment rates differed greatly across HMO plans, from a low of 4 percent to a high of 39 percent.

If disenrollment rules offer a safety valve for dissatisfied Medicare beneficiaries, high disenrollment rates may indicate some degree of disruption in continuity of care and some degree of financial exposure for beneficiaries who cancel medigap policies upon joining the HMO. Over 75 percent of Medicare beneficiaries who enroll in HMOs report having had private insurance prior to enrollment. Those who cancel that insurance may experience gaps in insurance coverage if they disenroll from the HMO. Analysis of interview data from the Evaluation of the Medicare Competition Demonstrations (Langwell 1987) indicates that approximately one of three previously insured HMO enrollees has continued to maintain that insurance over a year after joining the HMO. While some (23 percent) retain insurance because they receive it as a retirement benefit without cost to them, nearly 20 percent indicate that they maintain the coverage because they are uncertain about staying in the HMO or because they think its worth paying the premium to have the security of extra coverage. With Medicare supplemental coverage estimated to cost nearly $50 a month in 1988, some Medicare beneficiaries are paying a high price to protect themselves against the possibility of financial vulnerability if they choose to leave the HMO. Other beneficiaries who cancel their insurance after enrollment, however, may encounter high out-of-pocket costs for services they require after leaving the HMO, but before they can enroll in another private medigap program. The catastrophic proposals under consideration by Congress may reduce the extent of financial vulnerability of disenrollees. Even so, an information dissemination program designed to assist HMO enrollees to understand their insurance situation may be warranted.

FINANCIAL IMPACTS ON THE MEDICARE PROGRAM

Health maintenance organizations and case management may represent an opportunity to increase financial access to appropriate quality care to Medicare beneficiaries while containing costs to the Medicare program. If so, the Medicare program, Medicare beneficiaries, and HMOs that participate in the Medicare program may all benefit from this expansion of choices within the Medicare program. The limited evidence available for the under 65 population suggests that HMOs do save money, primarily by reducing hospital use. Most of the studies from which these findings are drawn, however, are based on the experience of a handful of well established atypical (for 1987) HMOs. Between 1976 and 1986 the number of HMOs in the U.S. increased from 236 to 595 with the number of IPAs increasing most dramatically from 41 to 345. Enrollment in IPA HMOs increased by over 2,000 percent over the past decade, while total enrollment in HMOs

increased nearly 400 percent. As a result of these significant changes in the HMO industry, it's unclear whether past studies of the effect of HMOs on use and costs of services are relevant to understanding and predicting the impact of Medicare HMOs. Similarily, the two studies that have suggested that HMOs have a one time impact on costs but do not slow the rate of increase in costs over time are based on limited data from the 1960s and 1970s when the type of HMOs operating were different from today and market conditions and competitive pressures were very different.

Even if these changes in the HMO industry and in market conditions had not occurred, previous studies of the impact of HMOs on use and cost of services have not been able to appropriately adjust for the nature and extent of biased selection. If persons who join HMOs are systematically healthier and/or prefer a low intervention practice style, then apparent differences in utilization of hospital and other services may simply reflect the differences in health status and "tastes" of HMO enrollees and all other persons. There is also the possibility that, even if reliable studies were available for the under 65 population, Medicare beneficiaries as a group may be different in their propensity to join an HMO.

The conclusion to be drawn from this discussion is that it's very difficult to estimate, at present, the savings (if any) to Medicare from the TEFRA HMO program. In the sections that follow, I will mention a few specific studies, completed and underway, that provide some information on whether HMOs may save money for the Medicare program.

Biased Selection

Whether HMOs save money for the Medicare program depends, in great part, on whether there is biased selection into Medicare HMOs. HCFA pays HMOs 95 percent of the adjusted average per capita cost (AAPCC) in the county of residence for each enrollee — in 1984 the per capita Medicare reimbursement was $1,974. However, nearly 40 percent of Medicare beneficiaries do not receive any reimbursements from the Medicare program each year (Lubitz and Prihoda, 1984). When these individuals enroll in an HMO, HCFA pays the HMO 95 percent of the AAPCC on their behalf. If a disproportionate number of these "zero reimbursement" beneficiaries (or low reimbursement beneficiaries) join HMOs, then the program can be cost increasing, rather than cost saving.

The nature and extent of biased selection into Medicare HMOs has been investigated by Eggers (1980), Eggers and Prihoda (1982) and by McCombs (1987) using data for prior use. Their results, for two group model HMOs and one IPA from the 1980 Medicare Capitation Demonstrations, suggest the group model HMOs experienced substantial favorable selection, but the IPA attracted enrollees who were representative of the market area.

GAO (1986) reports that mortality rates of Medicare HMO enrollees are considerably below the age-sex adjusted expected rate -- only 77 percent of expected mortality.[1] Since annual Medicare reimbursements for decedents are 6 times as high as for survivors, the lower mortality rates suggest that excessive payments to HMOs may be occurring.

Thus, there is some evidence, though limited, that suggests that biased selection may be an issue in the Medicare program. This evidence, however, is inadequate to develop clear policy directions. The Evaluation of the Medicare Competition Evaluation being conducted by Mathematica Policy Research for HCFA includes a study of the nature and extent of biased selection into Medicare HMOs. This study is focusing on 17,000 enrollees in 17 demonstration HMOs and comparing these beneficiaries to 17,000 nonenrollees in the same market areas. Prior use will be examined and, using survey data for a sample of these beneficiaries, characteristics, attitudes, perceived health status, and other factors will be considered. In addition, mortality experience over a two year period will be examined for these 34,000 enrollees. The results of this study will provide information on:

- o the nature and extent of biased selection into and out of Medicare HMOs
- o how biased selection varies among HMOs and geographic areas
- o the extent to which biased selection and mortality rates are related
- o the relationship between marketing practices and biased selection

These study findings will be available in Fall 1987 and will be extremely valuable for examining the rate setting methodology and the extent to which it reflects appropriately differences between Medicare HMO enrollees and nonenrollees.

Magnitude and Sources of Savings

If Medicare HMOs actually save money, the sources of these savings are important to understand to ensure that beneficiaries are receiving appropriate benefits and services and to enable the Government to refine the payment methodology. Sources of savings include:

1. Reductions in utilization of services compared to fee-for-service levels.
2. Efficiencies in provision of services that are not achieved by fee-for-service providers

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[1] Unresolved is the issue of the cause of the difference in mortality rates. Some portion of the difference might be attributable to better access, preventive care, and the different practice styles in HMOs.

3. Negotiated price discounts from providers below fee-for-service levels.

Through these mechanisms, HMOs may be able to provide appropriate quality care to beneficiaries at a cost considerably below 95 percent of the AAPCC.[1] If so, then it may be that the Medicare program could share in these savings to a greater extent than the current payment methodology allows. However, since HMOs are limited to "profits" on their Medicare enrollees no greater than the profits they earn on non-Medicare enrollees, a decision that payment levels to HMOs should be reduced will require that Medicare beneficiaries receive fewer benefits, pay a greater cost-share, and/or higher premiums for Medicare HMO membership. Careful consideration may be necessary to determine the potential negative effects of this change on the rate at which enrollment in Medicare HMOs will grow. This is particularly of concern if, as is discussed in the next section, Medicare HMOs have a beneficial competitive effect in the Medicare market.

I think it's also worth mentioning that there is considerable interest in developing methodologies for improving the AAPCC, both to account for biased selection and for the different utilization patterns within HMOs. (A recent paper by Newhouse (1986) summarizes the current status of this activity). Since HCFA has undertaken, through its evaluation contract with MPR, a comprehensive examination of biased selection and of the impact of Medicare HMOs on use and cost of health services of enrollees over a two year post-enrollment period, I would recommend that no changes in the AAPCC methodology or level be considered before these results become available and that testing of the revised methodologies be undertaken before contemplated changes are finalized. These studies of biased selection and use and cost impacts will provide a unique contribution to our currently limited understanding of HMOs and their financial effects.

Competitive Effects

One reason for introducing HMOs into the Medicare market was the perception that, in addition to direct savings, the Medicare program might benefit from increased competition in the markets in which Medicare HMOs operate. Possible market responses of fee-for-service providers include:

- a greater willingness of physicians to accept assignment for Medicare claims in order to retain patients who otherwise might join an HMO

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[1] Observing the generosity of benefits and minimal costsharing offered by most Medicare HMOs and the relatively low premiums charged to beneficiaries, it seems obvious that Medicare HMOs are providing all Medicare benefits for considerably less than 95 percent of the AAPCC.

- a greater willingness on the part of providers to contract with HMOs at negotiated rates below the established fee-for-service levels
- the formation by providers of new IPAs and PPOs to compete with established HMOs
- as more physicians gain experience with HMO practice patterns, their fee-for-service practice style may become more similar to the HMO pattern.

While there is little "hard" evidence on the competitive effects of HMOs, most studies that have been done were based on pre-1980 experience. The rapid growth and changes in the HMO industry in this decade suggest that competitive effects may be much more substantial today.

Evidence on the competitive impact of the Medicare HMO program is provided by physicians' willingness to contract with HMOs on terms most favorable to the HMO. I've been involved in site visits to 30 HMOs during the last five years focusing, in part, on the nature of financial arrangements between HMOs and physicians. Of these 30 HMOs, 16 capitate physicians for office based services and several capitate for referral physician services and other ambulatory services. A few HMOs are fully capitating large medical groups -- including for hospital and other institutional services. HMOs prefer to capitate in order to spread their financial risk to providers. Why are physicians willing to accept this financial risk? Medical group administrators with large, well known medical groups have told me that they do it because otherwise they will lose patients to the HMO and to the physicians who have agreed to these terms.

One final comment on competition and the Medicare program is useful. Under a grant from the Health Care Financing Administration, my colleagues and I at MPR, with the research arm of Medical Group Management Association, have for the past year been designing a demonstration that would test the feasibility of HCFA directly capitating large, well established medical groups for all Part B services to be provided to enrolled Medicare beneficiaries. These medical groups would assume full financial risk for Part B services and would also accept some limited degree of risk for Part A services.

During the design phase of the grant, we mailed information packets to just over 1,000 medical groups that met the minimum size and specialty mix requirements. It was our expectation that we might receive 30 to 40 responses from interested medical groups. Within two months of the mailing, 125 medical groups -- 12 percent of all medical groups contacted -- had responded that they would be interested in participating in a direct capitation demonstration. Several pointed out that, since they are already accepting capitation arrangements with HMOs, this opportunity could be an effective mechanism for increasing Medicare patientloads and maintaining

direct control over those patients' treatment.

My conclusion is that there is competition in the Medicare market -- researchers just haven't yet quantified it. The Medicare HMO program is, almost certainly, an important element in that competitive market. When policy changes affecting the Medicare HMO program are being considered, it would be sensible to consider whether these broader effects will be altered, also, and in what direction.

OPERATIONAL FEASIBILITY

The long run feasibility of the Medicare HMO program will depend upon the willingness of HMOs and Medicare beneficiaries to participate, as well as upon whether the Government can maintain its oversight role satisfactorily without incurring disproportionately high administrative costs. The fact that the Medicare HMO program has grown at a faster rate than was anticipated suggests that both HMOs and Medicare beneficiaries are willing to participate in the short run. However, it is clear that changes in Government management of the program could result in lower participation in the future.

Any new program tends to encounter startup problems that, in subsequent years, are corrected. Critics of the Medicare HMO program have focused on several issues:

1. Early problems with enrollment and disenrollment procedures. HCFA's awareness of these issues led to the CompuServe contract which now provides a more timely on-line system for recording enrollments and disenrollments.

2. Issues of financial solvency requirements when HMOs spread financial risk to providers.

3. The IMC deviations from the 50:50 rule.

4. Marketing practices and information and appropriate review mechanisms.

5. Protecting beneficiaries from gaps in Medicare supplemental coverage and gaps in service when HMOs and physicians discontinue participation in the program.

6. HMO compliance with requirements for grievance procedures and appeal rights.

7. Ensuring quality of care.

In this section, I'll briefly discuss each of these issues and, where appropriate, suggest some possible areas where changes in administrative oversight could encourage greater participation and, perhaps, relieve some concerns about the program.

Enrollment and Disenrollment Procedures

The current on-line system used by HCFA to record HMO enrollments and disenrollments has alleviated many of the concerns expressed during the early demonstration period about HCFA's ability to operate this aspect of the program. More recently, however, Senator Heinz has raised the concern

that some HMOs may enroll or disenroll beneficiaries without their awareness and with potentially catastrophic financial costs to the beneficiary. Although the Heinz report provides much anecdotal evidence, no firm data are available on the extent of the problem. Disenrollment patterns in several demonstration market areas, and for specific HMOs, were very high in the initial two years of the program. On the other hand, of 17 demonstration HMOs, 11 HMOs in 8 market areas had disenrollment rates under 12 percent annually while 6 HMOs in 2 market areas had disenrollment rates of 20-39 percent. The disenrollment survey conducted by MPR (Tucker and Langwell, 1987) asked 315 disenrollees from these 17 HMOs why they had disenrolled. Only 4 percent (6 people) of those who disenrolled within 3 to 9 months after joining said that they disenrolled because they had never intended to enroll.

It's unclear whether any administratively feasible mechanism can be put in place that would permit HCFA to identify cases where beneficiaries are intentionally falsely enrolled. If the occurrence is as small as our study would suggest (4 percent of disenrollees, and about 0.6 percent of all enrollees), it seems unlikely that any cost effective methods can be developed to address this issue.

With respect to HMO initiated involuntary disenrollments, HCFA presumably can retroactively reinstate the beneficiary and require the HMO to pay all out-of-plan costs incurred by the beneficiary, if it is proven that the HMO inappropriately disenrolled him/her. Substantial financial penalties might also be applied when an HMO has exhibited a pattern of inappropriate disenrollment. Again, the evidence does not suggest that this is a widespread problem and cost effective mechanisms to prevent any such occurrences may not be available.

Riskspreading and Financial Solvency Requirements

The GAO (1986) report turned particular attention to financial arrangements between HMOs and physicians in which the HMO transfers financial risk to the physician for a range of services up to and including all covered services. Solvency requirements apply to the HMO organization, but not to individual providers who are sharing in the financial risk. Thus, GAO raised the concern that Medicare beneficiaries may not be fully protected if an at-risk provider becomes insolvent.

There are a wide variety of physician incentive arrangements being used by HMOs at present (GHAA 1987; Langwell et al 1987; GAO 1987). Table 2 summarizes these arrangements in 20 Medicare HMOs. Table 3 summarizes these arrangements in 10 non Medicare HMOs. While the HMO is ultimately responsible for the financial obligations incurred on behalf of enrollees, insolvency of a risk sharing provider could create a situation

where beneficiaries receive bills and are distressed as a result. In addition, there is some concern that excessively high financial risk may cause some physicians to render poor quality care. Provisions in the 1986 Budget Reconciliation Act provide for a study of HMO-physician financial arrangements to determine whether HMOs should be prohibited from offering financial incentives to reduce use of services by Medicare beneficiaries. Legislation to prohibit most physician incentive arrangements could cause HMOs to leave the Medicare market, since they would lose a highly effective means of altering physician practice patterns. On the other hand, it may be appropriate to consider the quality and solvency implications of arrangements that put physicians at full risk for costs of all health care provided to Medicare beneficiaries.

TABLE 2

FINANCIAL RISK FACING PHYSICIANS IN 20 MEDICARE DEMONSTRATION HMOS

HMO	At Risk for In-Office Services	At Risk for Referral Physician Services	At Risk for Hospital Services	Limits to Risk/Other Arrangements
HMO A	Yes	Withhold and Bonus	Withhold and Bonus	$0 pays withheld, Maximum $1,000 for hospital services.
HMO B	Yes	Withhold	No	10% withheld for referral services. Bonus based on overall HMO profit on Medicare.
HMO C	Yes	Withhold and Bonus	Withhold and Bonus	Withhold
HMO D	Yes	Withhold	Bonus	$5,000 per member
HMO E	Yes	Yes, Outpatient	Yes/10%	Shared fees or surplus on hospital and inpatient specialists equally
HMO F	Yes	Yes	Withhold and Bonus	Withhold
HMO G	Yes	Yes/10%	Yes/10%	
HMO H	Yes	Yes	Bonus	Maximum negotiated ceiling put on Medicare group's losses.
HMO I	Yes	Medical groups- Yes IPA physician- No	A few groups have withhold; majority aren't at risk	
HMO J	Yes	Yes	Yes	
HMO K	No, Salary	No	No	
HMO L	No, Salary	No	No	
HMO M	No, Salary	No	No	
HMO N	FFS	Withhold	Withhold	Withhold
HMO O	No, Salary	No	No	
HMO P	No, Salary	No	No	
HMO Q	FFS	Withhold and Bonus	Withhold and Bonus	Negotiated maximum risk on referral and hospital costs.
HMO R	No, Salary	No	No	
HMO S	FFS	Withhold	Withhold	Withhold
HMO T	Staff Component, No	No	No	
	Group Component, Yes	Yes	Yes	

TABLE 3

FINANCIAL ARRANGEMENTS IN HMOS WHICH CAPITATE PRIMARY CARE PHYSICIANS OR PHYSICIAN GROUPS FOR NON-MEDICARE ENROLLEES

HMO	Services Covered Under Capitation Payment	Risk-Sharing Provisions for Hospital and Referral Care
HMO AA - IPA	The HMO capitates the IPA for: • all general primary care services • lab and x-ray The IPA capitates each primary care MD.	The IPA withholds 20% of the MDs' capitation, which is distributed to the MD if revenues exceed costs at the end of the year. Specialist MDs are paid from a "specialty pool." If the pool of funds for specialist services is not exhausted, remaining funds are distributed to P.C. MDs.
HMO BB - IPA (Network)	The group/individual MD is capitated for: • all ambulatory services, including ancillary and referral services • inpatient consultant fees	The medical group shares in any deficit or surplus in the fund from which the HMO pays hospital costs. If the fund incurs a deficit, the group pays the HMO up to 9% of its capitation payments for the period.
HMO CC - IPA (Network)	The HMO capitates the medical groups for all ambulatory services, including ancillary service and for inpatient physicians' services.	The HMO offers a bonus to the groups if hospital use remains under a predetermined target level.
HMO - DD - IPA (network)	The HMO capitates the medical groups for all ambulatory physician and ancillary services.	The HMO establishes a hospital claims pool. At the end of the year, funds retained in the pool are distributed to the groups.
HMO EE - Group	Capitation covers: • all ambulatory services • outpatient surgery • referral physician services • drugs • physical therapy • alcohol and drug treatment • ancillary services	The group practice is not at risk for inpatient care, although the HMO offers a bonus if hospital days per 1,000 are within a prespecified amount.
HMO FF - Group	Capitation covers: • all ambulatory services • ancillary services • referral physicians' services	Although the group is not at direct risk for hospital expenses, the HMO offers a bonus if hospital days remain within a prespecified target.
HMO GG - Group	HMO capitates the medical group for: • physician services • specialty referrals • ER • lab and x-ray	

IMC and the 50:50 Rule

IMC's rapid growth appears to be an aberration in the Medicare market. Of 20 of the demonstration HMOs that received site visits by the MPR team, the first year enrollment targets reported ranged from 500 to 25,000 with an average enrollment target across all 20 HMOs of only 5,791 Medicare beneficiaries. Only four of the demonstration HMOs expected to enroll more than 10,000 Medicare beneficiaries during the entire demonstration. Even with these relatively modest enrollment targets, only 10 of the 20 HMOs had achieved their enrollment targets at the end of the first year.

The 50:50 rule places a constraint on maximum combined Medicare and Medicaid enrollment relative to the plan's non-public enrollment. That rule was the only barrier encountered by IMC in its rapid expansion. However, it is perhaps more relevant to ask whether there should be some specific, maximum number of Medicare beneficiaries that a Medicare HMO can enroll or whether there should be a limit on the number of new Medicare

beneficiaries an HMO can add per year. Attention might also be directed to the ratio of revenues from the Medicare program to revenues from all other sources. The HMO industry is a relatively new one and even for long established HMOs, provision of care to Medicare beneficiaries who are sicker and require more and different services, is a new experience. A gradual, careful approach to expanding the Medicare HMO program and other capitation alternatives should be the general rule.

Marketing Practices and Information Dissemination

Few issues are more hotly debated than the role of government in monitoring and reviewing marketing practices. During the demonstration period, 50 percent of the HMOs complained that the review of marketing materials was a problem: review was slow, guidelines were ambiguous, and the process didn't take into account regional differences in market conditions. Currently, the review is placed at the HHS Regional Office level. However, concern has been expressed that standards and the review process vary across regions.

Marketing practices may result in Medicare beneficiaries enrolling under high pressure tactics, misunderstanding the enrollment option, and/or HMOs being able to market selectively to obtain favorable health risks. The main thrust of the recent Heinz report was on marketing practices. The report recommends that Congress should amend the Social Security Act to provide strict federal standards for the promotion, advertising and sale of Medicare HMO plans. This recommendation, if implemented, would relieve regional HCFA officials of responsibility for determining standards. However, unless carefully constructed, these standards could interfere with the ability of Medicare HMOs to compete effectively with Medicare supplemental insurers.

Another critical issue is the placement on HMO marketing staff of the burden of informing Medicare beneficiaries "lock-in" features and other aspects of the HMO option. It's evident from anecdotal evidence and limited survey data that some Medicare beneficiaries do not understand what they're joining when they enroll in an HMO. Of 305 surveyed disenrollees, 23 percent said they had disenrolled because they had not understood the HMO arrangements when they enrolled (Tucker and Langwell, 1987). The reasons for misunderstanding included:

- Did not realize I'd be off Medicare (2 percent)
- Did not realize I would have to switch doctors (12 percent)
- Services promised weren't available (3 percent)
- Did not understand out-of-area travel rules (1.3 percent)
- General misunderstanding (3 percent)

An early study of disenrollment from demonstration plans (Brown et al 1986) found that 45 percent of first year disenrollments occurred within 3 months of enrollment. This pattern strongly suggests that some Medicare beneficiaries were not getting adequate information on the HMO's advantages and disadvantages.

Under the TEFRA program, HCFA notifies beneficiaries shortly after enrollment that they are HMO members and what that implies about their relationship to Medicare and non-HMO providers. This letter is certainly helpful in ensuring that beneficiaries understand their HMO enrollment, but coming after enrollment, it doesn't prevent some beneficiaries from suffering gaps in continuity of care and incurring sometimes substantial out of pocket costs.

As the Medicare HMO program continues to grow, information will become less of a problem as Medicare beneficiaries and their families gain experience with HMOs and share this experience with other beneficiaries. In the meantime, greater efforts to disseminate information on HMOs to Medicare beneficiaries could be made by the Government and by consumer groups. It would be particularly useful to develop information programs in areas where the HMO option is just becoming available and where few beneficiaries have had prior direct contact with HMO practice arrangements.

Gaps in Financial Coverage and in Continuity of Care

Beneficiaries may face financial losses as a result of disenrollment from HMOs or as a result of termination of the HMO's Medicare contract. Similarly, continuity of care may be disrupted if the beneficiary disenrolls and their primary physician doesn't have a fee-for-service practice or if the beneficiary's primary physician terminates HMO participation. In the section on beneficiary effects above I have discussed the gap in insurance coverage when beneficiaries disenroll. With respect to gaps in service when beneficiaries disenroll, it is worth noting that over 20 percent of HMO enrollees continue seeing the same physician when they join the HMO and that 7 percent of disenrollees (12 percent of those who disenroll after a year) state that their reason for disenrolling was that their doctor left the HMO (Tucker and Langwell, 1987).

With respect to financial coverage gaps when beneficiaries disenroll, approximately 32 percent of Medicare HMO disenrollees did not have supplemental insurance before they joined the HMO; of those who did have insurance, nearly one-third retained it while enrolled in the HMO; and nearly a quarter of disenrollees immediately joined another HMO. Only a relatively small proportion of beneficiaries who voluntarily disenroll face insurance coverage gaps.

On the other hand, when an HMO terminates its contract with HCFA, its enrolled beneficiaries may face extended periods without supplemental

coverage. Senator Heinz suggests that coordinated open enrollment periods for all Medicare HMOs in an area would help alleviate this problem. Other options include (1) negotiating a cost contract arrangement with the terminating HMO to provide a bridge for enrollees to the supplemental insurance open enrollment period and/or (2) arranging with one or more traditional supplemental insurers to enroll Medicare beneficiaries when HMOs terminate a contract.

Grievance Procedures

A fairly complex internal and external grievance procedure has been developed for Medicare HMOs. Medicare HMOs are required to inform enrollees in writing of both the HMO's internal grievance procedures and of the external appeals process available to them. GAO (1986) reports that, for the first two years of the demonstration program, four Florida HMOs did not adequately inform enrollees of their rights. GAO recommends that a standardized explanation of the appeals process be developed and provided to HMOs for inclusion in member handbooks and other materials. In addition, GAO recommends guidelines for HMOs to follow in informing Medicare beneficiaries of internal grievance procedures.

While these recommendations may accomplish the objective of informing Medicare beneficiaries, given that the process is particularly complex the Government or consumer groups may want to consider: (1) informing beneficiaries directly of their appeal rights; and (2) establishing a system to provide assistance to enrollees with grievances that aids them to understand and implement the grievance process.

Quality Assurance

Assuring quality of care in Medicare HMOs has been a priority for HCFA, HHS, and Congress since the program began. Measuring quality is, however, a difficult and very costly task and there is no method for reviewing quality that is universally accepted. Mathematica Policy Research and Medical College of Virginia are conducting a multifaceted study of quality assurance programs and of quality of care, including patient satisfaction, access, and the process of care received for specific conditions and diagnoses.

At this time, only the study of quality assurance programs is complete.[1] Results of that study are very informative:

1. The majority of the HMOs studied had functioning quality assurance programs that met the requirements of OHMO for participation in the program.

[1]The study of satisfaction with care will be completed in Fall 1987. The clinical study of the quality of the process of care for basic care, colo-rectal cancer, and congestive heart failure will be completed in Spring 1988.

2. Some HMOs described elaborate quality assurance programs in their application to HCFA; however, these QAPs were found to be not actually functioning when site visits were conducted.

3. Some HMOs delegate responsibility for quality assurance activities to their physician provider organization rather than hire an independent internal medical director.

4. A number of HMOs rely on their utilization review system to identify quality problems. While UR does identify some types of problems quite effectively, it is not a QAP and will not detect the full range of quality problems that might be present in an HMO.

There's little or no evidence that a functional quality assurance program actually yields better health outcomes. However, there is a value to having an effective mechanism in place for identifying actual or potential quality problems, developing approaches to resolve problems, and a process for follow-up. Consequently, it was disturbing to discover that QAPs are not fully in place in all Medicare HMOs.

To some extent, the extension of PRO review to Medicare HMOs may alleviate concerns that quality is not being monitored in Medicare HMOs. In addition, there may be steps that can be taken that place a greater emphasis on the importance of quality monitoring in Medicare HMOs. For the Design of a Medical Group Capitation demonstration Under Medicare, MPR and Medical Group Management Association developed an approach to monitoring the operation of QAPS in capitated organizations that illustrates one possible system.

1. Medical group demonstration applicants must submit a description of their QAP, along with one year of QAP meeting minutes and medical record audit results.

2. Prior to the beginning of the demonstration, a site visit will be made to verify the QAP, to review past QAP activities, and to examine the medical record system.

3. Medical groups that aren't able to meet QAP standards will be required to meet those standards prior to enrolling Medicare beneficiaries.

4. A site visit will be conducted six months after the demonstration begins in order to review the functioning and results of the QAP activity. Medical groups not in compliance will be required to contract with AAAHC or another national accreditation group for review and accreditation. Failure to seek accreditation would result in cancellation of the medical group's demonstration contract.

5. Throughout the demonstration, medical groups will be required to submit detailed written reports on QAP activities on a quarterly basis.

6. External PRO review of quality of care will be conducted in demonstration medical groups.

While this level of intensity of review is more appropriate for a demonstration than for a full scale program, it does illustrate one comprehensive approach to quality assurance program monitoring. It also reflects the fact that the HMO written descriptions of their QAPs may not represent

the actual operating QAP. A PRO cannot rely on written documentation to assess whether a specific HMO is complying. On the other hand, continuing review of an HMO's QAP can require considerably less effort after the appropriateness of the system and its operational status has been determined. This implies that there may be high costs for initial review but that the cost of ongoing monitoring might be considerably lower for HMOs that meet all requirements.

SUMMARY

The Medicare HMO program offers beneficiaries a broader set of health care financing and delivery alternatives and, potentially, improved financial access to health services than has been available. The positive response of the HMO industry and of Medicare beneficiaries is evident by the expectedly rapid growth of the program since it was implemented in early 1985.

Capitation and case managed care may be the most effective mechanisms for ensuring financial access to appropriate quality of care, in an environment that includes strong pressures for cost containment. While not all Medicare beneficiaries will want to join HMOs, the competitive effects on fee-for-service providers may create additional positive responses that affect overall costs and practice patterns.

As with any new program, experience leads to refinements and improvements to administrative procedures. A number of changes in the Medicare HMO program have been made in response to experience during the demonstration period. Now with two full years of operational experience under the TEFRA program, it is useful to examine this experience and determine whether further refinements and improvements are necessary and operationally feasible. I hope that my remarks are useful as background to the Committee's deliberations on this issue.

Mr. MICA. Thank you all. Let me just extend thanks to everyone here. I'm going to call on Chairman Roybal for the first questions. Let me just have you keep this in mind as you respond.

I've served here 10 years on this committee, and I have found an interesting record for the Aging Committee, which is not a legislative committee, that virtually every major health recommendation that this committee has made has been enacted into law. So I want you to understand that as you give us this information, you really are giving input into a committee that has had a phenomenal legislative record.

I think the Chairman and Chairman Pepper before made it a point to see that there were one to two Members from every committee in Congress on this committee, for that very reason. Mr. Roybal.

The CHAIRMAN. Thank you, Mr. Chairman. May I add to that, we also have a pretty good record with regard to appropriations. I'm the only Member of this committee that sits on the Committee on Appropriations and I've been here for 25 years, so you can see that I have a little seniority in that committee. And we have been successful in many respects.

On the other hand, there are problems that are very difficult to solve, and we need experts like yourself to help this committee. And this again is one of the main reasons for this particular hearing. I would like to compliment each and every one of you for the testimony that you've given, but I do have some questions.

I was quite interested in, Mr. Gunter, in what you said with regard to twisting. You said that twisting involves changing the medicare HMO enrollee's membership from one HMO to another without the enrollee's knowledge, in order to make a commission.

Now, this is the first time that I've heard about that. Now, don't forget that I did not go and have not had hearings anyplace with regard to this problem. Now, how widespread is a thing like that?

Mr. GUNTER. Mr. Chairman, I'm glad you raised that question because that very practice is despicable in my eyes and I'm sure in the eyes of the committee. What we found was there were situations of sales people who were circulating so-called petitions to increase the security of residents in a condominium, and when the signed that petition, in reality they were signing up for enrollment in a different HMO. Or we found situations where there was the promise of a prize, maybe a radio or something else, for the condominium. When they signed the form, they were actually enrolling in a new HMO or there was the promise of a blood pressure test if they would sign the waiver for such a test, and in essence then they would submit these names to the new HMO, sometimes without the proper telephone number, sometimes without the proper address, so it would be difficult for the HMO to check it out. The procedure at that time called for immediate payment of commissions. Your specific question, how widespread, we found some 150 to 200 cases that we followed up on and investigated and in cooperation with HCFA. They worked very closely with us in this respect because of course they became knowledgeable about that type practice with the change in enrollment.

And this was a case of working side by side with them. We enacted specific regulations requiring that before the change in en-

rollment could be accomplished, that it had to be verified by the new HMO with the new enrollee that it was his or her desire. This must be done before any commission was paid. It had to be done in writing and had to be done by personnel who were not associated with the marketing facet of that HMO.

And we instituted substantial fines with respect to that type of practice. So as soon as it came to our attention, we took quick action, tough action, but it's a despicable thing that could occur around the country in other places.

The CHAIRMAN. What I'd like to know is whether or not we have that particular condition existing in the State of California. Ms. Skinner, do you know anything with regard to twisting?

Ms. SKINNER. I haven't heard about it in terms of the California HMOs and usually we hear very quickly when something like this does happen. We've heard other things, but not the twisting at all.

The CHAIRMAN. Well, I haven't heard about it. Of course, a Congressman usually is the last one to hear about anything, but I haven't heard that such a thing goes on in my area, but I wouldn't be a bit surprised if it did.

Now, let's suppose that it was in Florida and California and various States. We would then have to go to each State Legislature to license these individuals, wouldn't we? It could not be done on the Federal level, could it?

Mr. GUNTER. I presume the Congress can do anything it wants to do.

The CHAIRMAN. If you have the votes. If you have the votes.

Mr. GUNTER. Point well made, Mr. Chairman.

The CHAIRMAN. But I'm trying to examine the difficulty that's quite apparent in controlling such a thing. If the State Legislature itself doesn't act upon it and if there is no license of those individuals, then what business does the Federal government have to infringe its rule upon a State that is reluctant to act? These are matters that come up in debate constantly. Going through my mind is this tremendous problem that one would have in licensing these individuals, having to go to each State in the Union, if that is the condition throughout the country.

Mr. GUNTER. I'd like to emphasize that Florida has not been and was not reluctant to act. We did act immediately. We fined two HMOs $35,000 each. One of the issues that I think is central in this is it seems to me that there a responsibility on the part of the entity itself, the HMO, as to the practices and activities of their sales personnel. And in the creation of any licensing scheme, I think you need to continue that accountability.

We have found in regulating the insurance industry that many times they like to disassociate themselves from licensed agents who represent them and say oh, well, that was the practice performed by the agent and the company doesn't want to take the responsibility. We would like to see continued responsibility on the part of both parties and for the accountability to rest with both the HMO and the sales personnel, because oftentimes that is the strongest means to control such unsavory practices.

Mr. MICA. Mr. Chairman, if you don't mind, I'd just make an additional point on that. We've had not only twisting but what we call shifting. Twisting without their knowledge, shifting with their

knowledge. In Florida, HMO salesmen were the only insurance salesmen in the State that had no licensing requirement and they were literally given $50 per person for anybody they could sign up. And even the HMOs, and the one that we had problems with was concerned about the practice, salesmen would go out and sign 1,000 people for $50 a head, keep the list, and then go to work for another HMO, call everybody on their list and say, "I'm working for someone else. The people I signed you up with aren't as good. I found out some problems with them. Shift over to my HMO". And that's another $50 a head.

We had some salesmen who did this with three or four companies. We went to the State Insurance Commissioner and our legislature and asked that they act and in fact they had already been looking at this, and now there is a procedure, not quite licensing, but a good step in the right direction, that says that they have to come under some guidelines, like anybody else who sells insurance.

But certainly this is something where maybe the Federal Government can't mandate everything, but certainly minimum standards and some kind of licensing for those who sell these kinds of things should be required.

The CHAIRMAN. I think this committee should very carefully look into proposed legislation along those lines. And I say this because Mr. Gunter, as you told this committee that you we are considering legislation for presentation to the next Florida legislature to require the licensing of HMO sales representatives.

Mr. GUNTER. Mr. Roybal, that's true, but I hasten to emphasize we took the regulatory action which I described to you, which was to require a reporting procedure wherein we assure that the individuals who might be shifted, who might be the pawns in this sordid game, would in fact be notified that, it would be verified that was their specific choice and that if it was not that we would then be able to take action against the HMO and the salespeople involved.

The CHAIRMAN. We will still consider legislation along those lines and see what we can do. Now, the next thing, Ms. Langwell. What did the lessons from the medicare demonstrations and from the current medicare HMOs suggest as to how to proceed in the future?

Ms. LANGWELL. Well, I think as I said in my opening statement, the most important thing is making sure that consumers have all the information that they need in order to make informed decisions and that means perhaps doing more than just relying on the HMOs to inform them, in advance, of what it means to join an HMO and of what their grievance rights are and what their appeals procedures are. I think more information has to be provided to medicare beneficiaries to allow them to make informed decisiona. The HMO program is still very new, in the medicare market, especially, it's very new, and information is probably the most important protection that you can provide for medicare beneficiaries.

The CHAIRMAN. Now, quite likely we will not have the time to question each and every one of you. What I would like to impose on you is a further duty, if you would be so kind as to do this.

Please write me a little note and answer this question.

What should be done to increase HMO participation in medicare, and beneficiary participation in medicare HMOs?

In other words, you're writing to me and telling me that we think that your committee should look into this and do this and the other. I would greatly appreciate that.

Once we receive that, I'm going to carefully review what you have written and then I'd like to meet with you individually, and see if we can really work together to bring about some changes. If we don't really continue this dialogue, and just end it with this hearing, we'll just have a hearing and then forget about it tomorrow and nothing will be done.

It seems to me that we should continue at least talking to one another and see if we can, together, bring about some changes.

Mr. MICA. Thank you, Mr. Chairman. Ms. Bentley.

Ms. BENTLEY. I just have a couple questions I'd like to ask of the witnesses. And I thank you, Mr. Chairman, for having this hearing and do you think that the language is moving along at a very fast pace? We hear a lot about it. Good and bad.

Mr. Gunter, did IMC have a greater rate of complaint about the quality of service than other HMOs in your State?

Mr. GUNTER. Ms. Bentley, I am not aware that they had a greater percentage rate of complaints. They were the largest HMO in Florida so they had a lot of complaints. But I am not aware that they had a higher percentage, when you look at their total membership. Bear in mind, we received some of those complaints and the Department of Health and Rehabilitative Services received others. Congressman Mica's office and perhaps other Congressional offices received some. So there was a wide range of reporting in calculating those complaints.

Ms. BENTLEY. It's my understanding that the problems in IMC were centered at top levels of management and not with the providers and mid to low management. Do you agree with this assessment?

Mr. GUNTER. Generally so.

Ms. BENTLEY. Do you think that we might be in danger of the possibility of losing a comprehensive selection of services at lower cost if government start loading HMOs down with all sort of Federal and State requirements and regulations?

Mr. GUNTER. I don't think so. As I suggested in my earlier statement, it seems to me with the tremendous growth on the part of some HMOs, particularly certain medicare contracted HMOs, that a greater degree of oversight at the Federal and State level is in order and in the public interest.

Ms. BENTLEY. Ms. Langwell, how would the various catastrophic care bills affect HMOs and will they be forced to provide services like prescription drugs if they are not already providing them in the HMO benefit package?

Ms. LANGWELL. I suppose that depends on how the catastrophic bills that finally pass are written. I think one of the major advantages of the catastrophic bills is that it would protect medicare beneficiaries to some extent who move into and out of the medicare HMOs. It allows them to drop the medigap insurance and yet disenroll from an HMO if they're unhappy with the care that they're receiving without being afraid of incurring monumental copay-

ments and deductibles for the first few months after they move out of an HMO.

Ms. BENTLEY. They would be protected all the way across?

Ms. LANGWELL. That's right.

Ms. BENTLEY. That would be important.

Do you suggest that HMOs should be required to have a case manager and social service workers, mental staff, and geriatric medicine, specifically responsible for resolving the problems of medicare beneficiaries. Why is it necessary in your view?

Ms. SKINNER. I feel that it's very important that a case managed system be put into effect. It has proven itself in many cases to benefit the patients and it certainly has proven itself to be cost effective. Case management is necessary. It is vital that professional personnel with a large population of older people be well trained in gerontology and geriatrics. I feel that professionals should be trained when they come in the program and that there should be ongoing inservice education for all HUD staff because dealing with the problems of the older person, whether they be medical, social, psychological, whatever, are much more complex and completely interrelated. In a younger person you could have an illness that can be taken care of, the patient gets better and that's the end of the picture. The absence of one or more of these professionals from an HMO noticeably affects the delivery of health care to Medicare beneficiaries.

The CHAIRMAN. I think it depends on the level of the personnel. Certainly it would be necessary to have well trained physicians at all times and certainly nurses. Very often you'll find on a case management program though that often the various disciplines substitute for each other and there is often a situation where self selection occurs where the nurse may be the case manager, and so forth.

Ms. BENTLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Ms. Bentley.

Mr. MICA. Mr. Crane, you mentioned a little bit about revising the payment mechanism. Is Kaiser a profitable operation?

Mr. CRANE. Kaiser is a not for profit organization but we generally——

Mr. MICA. They meet their bills, though?

Mr. CRANE. Yes, we do.

Mr. MICA. They're not losing money?

Mr. CRANE. Correct.

Mr. MICA. And you want to rewrite the formula so they would get more money?

Mr. CRANE. That is not the issue. The suggestion was made in the context of attracting more HMOs to the risk contract program. One of the things that many HMO's are concerned about is that the payment system is not adequate. There has been a recent study, I think done by Rand, which showed that the AAPCC cells, that is age, sex, welfare, institutional status, explain a very small percentage of the variation of a medicare beneficiary's medical care costs.

The idea system would be to pay an HMO related to the risk of the members that are being enrolled so that an HMO is neither over or under paid and has an incentive to enroll the sick as well

as the well. There is a considerable amount of effort at the Federal level in HCFA examining the current AAPCC methodology to find ways to improve it.

Mr. MICA. A preliminary study that indicated that they may indeed be paying too much?

Mr. CRANE. I'm not familar with that although it is conceivable that if an HMO enrolled only well beneficiaries and was paid for beneficiaries who were of average health, they might be overpaid. Now the whole notion is that an HMO will enroll a balanced population.

Mr. MICA. In the legislation that we've introduced, and I don't know whether it's one of the provisions that's already been enacted or one in the new piece of legislation, we're asking for review and a regular reassessment, so that where the capitation rate needs to be raised, raise it; where it needs to be lowered, lower it.

We don't want to force any operator, nonprofit or for profit, to run on the edge and make health care decisions that are so closely related to their financial solvency that it really impairs their judgment.

So I appreciate that. Any information that you could provide would be helpful.

Let me just ask this and clear this with the whole panel. As we start to bring this to a close, would the entire panel agree that the HMO concept is a good concept and should be pursued, perhaps with additional oversight and regulation, but certainly one worthy of governmental support, State and Federal, and a concept that can indeed provide a new range of health care for seniors? Any disagreement on that?

Let me ask you, Mr. Gunter, in regard specifically to Florida, were you pressured in any way politically or otherwise improperly with regard to your oversight of IMC?

Mr. GUNTER. No, sir, I was not.

Mr. MICA. You had a free hand with regard to the entire matter?

Mr. GUNTER. I certainly did.

Mr. MICA. Do you feel there are specific areas where the Federal Government didn't move quickly enough? Our hearings did start 3 years ago. There has been criticism that the Congress didn't do enough, that you didn't do enough, or that the Federal Government didn't do enough. Why did it take 3 years? Did we not have or did you not have the adequate authority, did the Federal Government not have authority, were they remiss?

Mr. GUNTER. I think everybody is clear as to the history of HMOs and specifically IMC. IMC began as an entity with three small clinics in south Florida. They were very small comparatively speaking, until the beginning of the Federal experiment with medicare in 1982 and that of course gave them the tremendous growth which we have seen.

I don't know whether there was the anticipation of that type of growth, but with growth, with bigness, with the dollars that were infused, there came these management problems and all of the other problems, Mr. Chairman, that I think related to that specific HMO and perhaps others in the overall program.

Frankly, I believe the administration and Congress early on created somewhat of a toothless tiger in the oversight of those medi-

care HMOs. And I think the testimony that Dr. Roper presented here earlier today would indicate that they are seeking and perhaps in the past have sought tougher sanctions, the ability to move more quickly, the greater flexibility that was needed with all of the Federal dollars involved, in that size of a program.

Mr. MICA. Do you have other HMOs in Florida that have problems like IMC?

Mr. GUNTER. Not like IMC. We have other HMOs which obviously we are——

Mr. MICA. Solvency problems?

Mr. GUNTER. I don't know that you would call them solvency problems per se. I certainly don't want to create any kind of a run on the bank. But we have HMOs in Florida, Mr. Chairman, to be sure, that we are looking at very closely and monitoring very carefully.

Mr. MICA. Is the reinsurance agreement or insurance agreement arrangement adequate? Will IMC have enough insurance to pay all of its debtors, and should the Federal Government raise the ante on how much an HMO should hold in reserve in case there is—I think Dr. Roper said many have failed and I guess we assume that more will fail. Do we all need to raise——

Mr. GUNTER. Mr. Chairman, I would urge this committee and the Congress and administration to take whatever steps that you can to protect the Federal dollars involved in this program.

Obviously we require the insolvency insurance which you are now dealing with in the case of IMC and we in the insurance department in Florida are going to use every legal tool to require payment of those claims as we see it. As sometimes happens in insurance claims, there are disputes. And I'm sure that State Mutual, which is the company here, is going to utilize whatever remedies in the framework of the law that they have. But we in our role are going to do all possible to require the payment of claims because we think it's a just claim.

As you know, there is a disparity in the reporting of the amounts of claims that creditors have outstanding. There are legal challenges.

Mr. MICA. What is the figure?

Mr. GUNTER. That is a figure that is not available to me. I don't know of an accounting at this point in time because of the discrepancies in the amounts that are being claimed, and the litigation that is in the process, before the State stepped in.

Mr. MICA. Let me ask one last question. You heard me say at the very beginning of this hearing, we had a $400 million Federally funded operation that told this committee that 5,000 to 50,000 documents were first shredded, then lost in the computer, and finally fell off the back of a truck.

We hate to close this hearing not knowing what happened to those documents.

Were you able to find out, or do your investigators have any information?

Mr. GUNTER. We were never able to find those documents. Unfortunately, there are other documents we also have not been able to find.

Mr. MICA. In closing let me just thank each of you for being with us. There's a great deal of testimony that's been submitted that I think has a great deal of substance and I am looking forward to reading each and every sentence carefully. I can pledge to you and this committee that we'll continue to do everything to work with the appropriate committees in Congress to make sure that the Federal Government does its role and the Congress carries out its responsibility. We hope that other States will take some of the leadership roles that we've seen in the State of Florida. And I'd like to ask you as Chairman Roybal did that if you have any additional information when you get home that might be helpful to us, please include that in your statement because I really do believe HMOs will continue to prosper, they will grow, some will fail and we need to have the appropriate oversight and the best legislative approach possible.

The record will remain open for 2 weeks for anyone at the table or otherwise who would like to submit possible testimony for inclusion.

Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Chairman. I would like to thank the witnesses not only for their excellent testimony but thank them also for coming to this hearing at their own expense. The committee as you know has been reduced in funding and we are unable to offer you a first class ticket on any airline. We are grateful for the fact that you're here, that you've financed your own trip and grateful for the information that you've given us.

Mr. Crane, I realize that you're a pinch hitter in this event. But I would like to express my appreciation to you personally and please convey to Mr. Erickson our best wishes for a speedy recovery.

Mr. CRANE. Thank you very much.

The CHAIRMAN. Thank you. The hearing is now adjourned.

[Whereupon, at 1:55 p.m. the hearing was adjourned.]

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APPENDIX

DR. WILLIAM ROPER, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION,

ANSWER TO WRITTEN QUESTION SUBMITTED BY CHAIRMAN EDWARD R. ROYBAL

What can and should be done to increase HMO participation in Medicare and beneficiary participation in Medicare HMOs?

The most important step to increasing HMO participation in Medicare and beneficiary participation in HMOs is allowing HMOs to compete on price and quality and quality of services, increasing their attractiveness to the Medicare beneficiary. Similarly, we want to make Medicare participation more attractive to HMOs and thus increase their availability to Medicare beneficiaries. In sum, our goal is to offer Medicare beneficiaries a wider range of health plan options among which to choose, so that beneficiaries could select the health care plan that best meets their individual needs.

We have proposed legislation, the Medicare Expanded Choice Act, that includes provisions that will make it easier for HMOs to predict their costs and assume risk for an enrolled Medicare population. These provisions include a multiple year contract option where the Medicare payment rates would be known farther in advance; elimination of the requirement that organizations provide additional benefits; expansion of the definition of eligible organizations to include employment-based plans; elimination of continuous open enrollment; and modification of certain administrative requirements.

In addition, we have proposed legislation that will repeal the title XIII HMO Act requirements. HMOs would compete with other providers and health insurers who provide prepaid health care options. The HMO industry has fully developed since enactment of the HMO Act in 1973 and no longer needs Federal interventions such as "dual choice".

Consistent with our legislative program, we are proposing to eliminate the regulatory requirement that employers make the same contribution to HMOs as they make to their indemnity health benefit plans.

These legislative and regulatory changes will promote a competitive health care marketplace that increases the choice of cost-effective health plans to beneficiaries.

In addition, we have initiated a public affairs plan to increase beneficiary awareness of the prepaid health care option offered by HMOs. Activities in this area include public service announcements that will begin on a test basis in three areas in September; radio messages by Secretary Bowen; and increased information through our normal public information channels.

Finally, we recognize the need to assure beneficiaries who choose to enroll in HMOs that they will receive quality care. We are implementing an independent review of care provided in HMOs that contract with Medicare on a risk basis. We have initiated a complaint tracking system, and are proposing legislative amendments to give us additional authority to penalize plans that fail to meet requirements, for example to suspend enrollments for plans that overcharge on premiums or improperly enroll beneficiaries.

SUPPLEMENTAL TESTIMONY OF KATHRYN M. LANGWELL, SENIOR ECONOMIST, MATHEMATICA POLICY RESEARCH, WASHINGTON, DC

Participation in the Medicare HMO program, by HMOs and Medicare beneficiaries, has grown more rapidly than was anticipated when the TEFRA regulations were issued in early 1985. Nearly one-third of HMOs and over 900,000 Medicare beneficiaries are participating in the program only two years after its implementation. Further expansion of the program may develop more slowly for a number of reasons and the actions of Congress and the Department of Health and Human Services can substantially influence this future growth. An important question to consider, in addition, is whether rapid expansion is desirable or whether slower, more gradual increases in program participation will yield better long-run results.

Medicare Beneficiary Participation

Medicare beneficiaries join HMOs when they are offered the option, if they know someone who is familiar with the HMO (or HMOs, in general) and if the benefit package is sufficiently attractive. The findings from the Evaluation of the Medicare Competition Demonstrations suggest that participation may be increased in several ways:

1. Increasing the number of HMOs and other capitation arrangements available to Medicare beneficiaries, particularly in areas where none currently exist, would increase participation.

2. Greater "generic" HMO marketing efforts by the Medicare program and by organizations representing older Americans would increase Medicare beneficiaries awareness of HMOs as an option and, in addition, would increase understanding of the HMO option and its unique features.

3. Maintaining the payment rate to HMOs at a sufficiently high level to permit HMOs to continue to offer attractive benefits packages and reduced cost sharing will encourage participation.

4. It is important to recognize that Medicare beneficiaries interest in the program will be affected by bad publicity and by a perception of uncertainty about the stability of the program and its financial arrangements. Appropriate monitoring of Medicare HMOs and CMPs will minimize bad publicity. Care may also be taken in modifying payment arrangements and other regulations that may cause disruptions in the program that undermine beneficiaries' confidence.

Not all beneficiaries will want to join HMOs; less than 1 percent of affluent Medicare beneficiaries join when HMOs are offered. However, over 20 percent of poor, but Medicaid ineligible, beneficiaries join, suggesting that the program may be a useful mechanism for increasing financial access to care. That, more than cost containment considerations alone, may

justify expanding the program to make HMO options available to as many Medicare beneficiaries as possible.

HMO Participation

Participation by HMOs in the Medicare program is already quite high after only two years. While more HMOs may be drawn into the program over time, it is unlikely that all HMOs will -- or should -- participate. HMOs in low AAPCC areas and those that are less efficient in controlling utilization patterns should resist the temptation to participate in Medicare since they have a higher probability of financial losses under the program. Although only 9 HMOs have withdrawn from participation in two years, an increase in withdrawals would undermine beneficiary confidence in the program.

Since HMO participation is already substantial, the important issue is whether participation will continue at the current level or whether HMOs may choose to withdraw from Medicare risk contracts over time. Continued participation may be encouraged in several ways:

1. The payment rate can be set at a level that permits HMOs to generate surpluses that can be used to offer benefit packages that are attractive to Medicare beneficiaries.

2. Refinements to the AAPCC methodology that more appropriately reflect the financial risk of enrolling Medicare beneficiaries are under study. However, it would be preferable that these refinements be tested in a demonstration program for a period of time before being implemented. Confidence of HMOs in the program may be severely undermined if changes in the methodology and level of payment are introduced and then altered several times over a few years.

3. Not requiring HMOs to offer specific supplemental benefits, not included under Medicare, which may reduce their ability to compete with Medicare supplemental insurance and to respond to consumer preferences in local markets.

Results of the Evaluation of the Medicare Competition Demonstrations suggest that a primary concern of HMOs in the Medicare market is that the Medicare program will alter the payment level and methodology erratically and often, making it difficult to plan and to offer a stable benefit package to Medicare beneficiaries. Continued high participation of HMOs in the Medicare program may depend upon the HMO industry's perceptions of the stability of the program.

Bob Graham
STATE TREASURER
INSURANCE COMMISSIONER
FIRE MARSHAL

State of Florida

Department of Insurance and Treasurer

THE CAPITOL
TALLAHASSEE 32399-0300

June 25, 1987

Honorable Edward R. Roybal, Chairman
Select Committee on Aging
U. S. House of Representatives
Room 712, Annex One
Washington, D. C. 20515

Dear Representative Roybal:

I certainly appreciate the opportunity to appear before your Select Committee on Aging and offer testimony at your hearing on June 11. At the conclusion of the hearing you stated that you would like to receive additional input as to what actions should be undertaken to bring about changes in the health maintenance organization industry, especially as it relates to the medicare enrollees.

First, I would urge you to continue the health maintenance organization medicare concept. It is a viable concept and one which should be nurtured and continually improved. Specifically, however, I would urge you to consider the following changes in the health maintenance organization medicare concept:

1. Offer more flexibility in the interim sanctions that may be undertaken for any health maintenance organization in violation of the federal rules or statute. Interim sanctions should include suspension of enrollment or administrative penalties such as fines. Florida has just changed its statute so that our penalties include revocation, fines, or suspension.

2. Consider some alternatives for the enrollees where a health maintenance organization cancels its medicare contract. I would suggest that the health maintenance organization be required to cover pre-existing conditions between the contract termination date and the end of the waiting period for a medicare supplement insurance policy.

3. Further strengthen the marketing practices legislation. The marketing practices which transpired in South Florida are despicable and should never be allowed to occur again. We have, in Florida, rules now in force that should stop these practices. As I stated in my testimony, we are currently considering licensing in Florida for medicare salespeople; however, you may want to consider that on the federal level.

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4. Be substantially more cautious in approving any further exceptions to the 50/50 medicare commercial enrollee.

5. Consider legislation that would not allow the Federal Government employees to retire from their regulatory role and immediately assume employment with a health maintenance organization. This type of legislation is also being considered on the state level.

6. Review the staffing levels of the Health Care Financing Administration to ensure that they are adequate for good enforcement of the health maintenance organization, rules, and regulations.

7. Continue to evaluate and refine the quality assurance mechanisms.

The changes listed above need to be considered on the federal level due to the federal financial commitment to this program. As you know, Florida has taken an active role in marketing practices oversight, is considering licensing health maintenance organization salespersons, has recently further strengthened its quality assurance mechanisms, and will shortly be drafting legislation to increase the financial requirements of health maintenance organizations.

Again, I am glad I had the opportunity to appear before your Committee. If I can be of any further assistance, please don't hesitate to call me.

Sincerely,

Bill Gunter

Bill Gunter
State Treasurer and
Insurance Commissioner

BG/jlv

cc: Honorable Daniel A. Mica

KAISER PERMANENTE

Executive Offices, Ordway Building

July 15, 1987

The Honorable Edward R. Roybal
Chairman
Select Committee on Aging
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Roybal:

This is in response to your request for a written response to the question, "What can and should be done to increase HMO participation in Medicare and beneficiary participation in Medicare HMOs?"

We are pleased to provide you with the following recommendations:

1. The adjusted average per capita cost (AAPCC) methodology needs to be improved so that HMOs will be adequately paid for beneficiaries of different risk classes. While the Health Care Financing Administration (HCFA) is carrying out research on this issue, it is important for the Congress to continue to place high priority on it.

2. It is important to promote understanding of and stability in the HMO payment methodology. Some HMOs have been reluctant to participate in Medicare because they believe that the "rules of the game" are likely to change in unpredictable ways. Observing the changes that have occurred in Medicare's perspective payment system for hospitals adds to their anxiety. There is a need for the Congress to assure that the "rules of game" are stable over time. It is also important that they are more clearly understood. One step in this direction would be to require that the AAPCC methodology be set forth in regulations, so that the factors, assumptions and details of the methodology are published and changed using a public process.

Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza Oakland, California 94612 415-271-5910

3. There is a need to assure that only reputable organizations participate in the Medicare Program. This can be accomplished by having sound standards for the qualification and certification process. For example, we believe that only HMOs or CMPs that are attractive to the population at large should be offered to Medicare beneficiaries. The Congress should continue to insist upon strict application of the 50/50 rule, except in rare and carefully monitored instances.

4. Once approved for participation, HCFA oversight of plan operations is necessary. We would urge a review of HCFA's staffing levels to assure that the staff is adequate to properly perform monitoring responsibilities.

5. It is important to evaluate and refine the quality assurance mechanisms on an ongoing basis. The methodology that will be employed under PRO review has never been tested. It is important that it be carefully evaluated as it is implemented. Because the state of the art of review of quality in HMOs is still in its infancy, it is important to encourage diversity in approaches to this task. We believe that the best assurance of quality of care is the commitment of an HMO or CMP to that goal. A number of HMOs have spent considerable effort to develop effective quality assurance programs and it is important that PRO review does not stifle such innovation in quality assurance and lead to decreased emphasis on internal activities.

By taking action to deal with the issues above, we believe that the long-term prospects for Medicare HMOs will be good. The key to increasing beneficiary participation will be attracting HMOs with solid reputations in their communities and allowing those organizations to show Medicare beneficiaries the benefits of organized systems. A growing number of elderly citizens can and should have an HMO option, although it is important to recognize that capitation is not a panacea. We stand ready to assist you and your committee and others in the Congress with modifications of the risk contract program so that a significant number of senior citizens have the option of joining a prepaid group practice or other HMO of good value and sound quality.

Thank you for your interest and leadership in this matter.

Sincerely,

Robert M. Crane
Vice President -
Government Relations

SENATOR CHARLES D. COOK, CHAIRMAN, NEW YORK STATE LEGISLATIVE
COMMISSION ON RURAL RESOURCES

Inadequate Transportation Service Impedes the Delivery of Health Care to Older Rural Citizens

Mr. Chairman and Members of the Select Committee:

I appreciate the opportunity to present the issue of rural health care from my perspective as chairman of the New York State Legislative Commission on Rural Resources. The Commission is a bi-partisan legislative study group established by Chapter 420 of the Laws of 1982. Our mission is to promote those policies and programs that will enhance the quality of life for the state's three million rural residents and also preserve and develop the indigenous resources found in our vast rural areas.

The Commission has conducted four statewide symposia on various aspects of importance to our rural citizens and has held 20 public hearings around the state. We have published numerous reports and sponsored various legislative measures. Among the vital elements we have found that help sustain rural life and economics is the rural health delivery system. As you are aware the rural health delivery system is currently experiencing significant new challenges that could seriously threaten the accessibility and affordability of health services for all rural citizens in this nation, and especially our growing elderly population. This situation exists in rural New York as well. Repeatedly, we, and others who are working on behalf of rural communities, have also been reminded of the critical nature of transportation services in rural health delivery.

As the nation's and New York State's population ages, our society has a most difficult task in ensuring an equitable quality of life with adequate service delivery, income, health services, and housing for older persons. This goal proves to be most difficult to achieve in rural areas of New York State because of the overall lack of public transportation and community support systems. According to a recent Commission study, of the 44 rural counties in New York State, only 21 have some form of public transportation service and 23 do not have any service at all. And for those counties that have some form of public transportation service, even these have systems that are relatively underdeveloped.

There is an increasing rate of growth in New York's rural elderly population, with current projections estimating that this rate will exceed the urban aging population growth rate by a ratio of three to one by the year 2010. It is also anticipated that this population segment will live longer and thus require health and related services for a longer period of time than has been experienced in the past.

The challenge of providing health services to the elderly in rural areas is most pressing with regard to frail women. The average life expectancy of females is projected to increase from 77 to 81 years over the next couple of decades. Older women outlive men by six to seven years, and most often find it difficult to maintain an independent lifestyle in a rural area when the husband dies, especially if they never learned to operate an automobile or have developmental disabilities which reduce personal mobility.

Compounding the problem is the fact that a relatively large proportion of rural older women are at or near the poverty level. 21 percent of those persons 65 or older had incomes that qualified them as "near poor," calculated as between the poverty level of about $5,000 and 125 percent of that level for an individual. In rural areas the average income of an older couple is 20% less than that of a comparable couple living in a metropolitan area.

Recent data also show that as the number of older men in the work force declined, the number of older women actually increased. Older women are experiencing economic pressures to work beyond the retirement age, since retirement or social security benefits reflect past income levels and women as a group have earned less than their male counterparts. Older women in rural areas are hard hit by these economic pressures. Not only do they make less than their male counterparts both urban and rural, they also have limited job opportunities in rural New York to supplement their incomes.

Recent trends toward the closing or consolidation of rural hospitals and other health care resources threatens to further reduce access to affordable services for the expanding elder population. Also, there exists a great shortage of sub acute care and long term care services in rural New York. Travel time and costs and the possibility of increased isolation from friends and family will increase as distance to facilities increases. Older infirmed persons in rural New York, the majority of whom are women, are particulary vulnerable since they are more invisible and inaccessible to those who try to offer care. Moreover, state and federal delivery programs, designed to help all older persons, often fail to meet the needs of rural infirmed older

persons because they do not take into consideration unique rural delivery problems. For example, in-home health services, respite care and adult day care programs for the elderly may prove ineffective or very costly in rural areas because of the shortage of home and personal care aides and other qualified personnel. In rural areas home aides are especially difficult to attract because of low wages, additional transportation costs and unreimbursed travel time between clients.

Transportation problems have long been the biggest impediment both to effective rural health service delivery and to maintaining the independent status of older rural residents. The long distances in rural areas make it difficult to either bring older persons to needed services or bring such services to them. This problem is especially acute for older women who retired with their husbands to rural areas from the cities and never learned to drive. When widowed and living alone they are, in most cases, without any form of transportation. A study by the N.Y.S. Senate Standing Committee on Aging shows that only 33% of rural New York's 65-plus single, female-headed households have an automobile available. This points out a glaring fact for rural New York's older population: being a single, older female means additional hardships due to the lack of both private and public transportation.

Adequate housing, medical, business, and psychosocial services are essential components of meeting the health needs of the rural elderly, but are useful only to the extent that transportation can make them accessible to those in need. Far too often, however, existing federal and state policies and programs that support transportation services have been overly fragmented and limited to serving the specialized needs of narrow client-specific populations. The dispersion of rural populations over relatively large areas makes such an approach impractical and complicates the design of cost-effective, efficient transportation networks for rural areas. However, the task requires special attention to unique rural conditions and the coordinated use of available resources.

It is essential that disparate funding streams and resources that may support rural transportation be integrated and that networks be designed so that they are tailored to local circumstances, rather than as clones of urban mass transit systems. Recently, the Governor and the Legislature in New York State have recognized the problems associated with the lack of public transportation in the state's rural areas and the need for a special approach. A Rural Public Transportation Coordination Assistance Program was introduced in the

1986 legislative session by the Commission on Rural Resources and signed into law by the Governor as Chapter 888 of the laws of 1986. This legislation provides a comprehensive state policy for the coordinated development and operation of public transportation services in the state's rural areas. However, in order for this program to effectively serve the large number of transportation disadvantaged rural residents in New York, continued and enhanced federal support is required. Moreover, disparate funding streams and policies for rural public transportation must be integrated at the federal as well as the state and local levels. Available resources are just too few in rural areas for client specific transportation programs to survive, let alone expand service delivery for a growing transportation disadvantaged population.

Most recently, bi-partisan legislation has been introduced by the Commission on Rural Resources in the 1987 legislative Session (S.3875-A and A.5564-A) which would encourage public school districts who own school bus systems to contract to provide transportation related services for rural counties that implement coordinated public transportation systems under the chapter 888 local assistance program. Currently, hundreds of millions of dollars are spent on transportation for pupils attending rural public schools each year. These facilities represent a significant untapped resource that could be used to transport other transportation-needy people. It is hoped that such efforts will enable older and other transportation disadvantaged rural residents to have access to the health and community services and support groups which are vital to securing and enhancing their quality of life.

Thank you for this opportunity to present testimony about meeting the health needs of older rural citizens.

PREPARED STATEMENT OF HENRY MINEUR, PRESIDENT, AMERICAN MEDICAL CARE AND REVIEW ASSOCIATION (AMCRA), BETHESDA, MARYLAND

Mr. Chairman, my name is Henry Mineur. I am President of the American Medical Care and Review Association, AMCRA, on whose behalf I appear before you today.

AMCRA is a national association of some 500 health maintenance organizations (HMOs), competitive medical plans (CMPs), individual practice associations (IPAs), preferred provider organizations (PPOs), foundations for medical care (FMCs), and other alternative health care delivery organizations committed to offering individuals and their families a choice of health care in their communities. AMCRA's diverse organizations and individuals support pluralistic alternatives among health care plans that emphasize appropriate use of health care facilities and services, quality care, universal access and reasonable cost. The organizations that make up AMCRA represent a combined enrollment of more than 6 million Americans and involve the participation of 110,000 practicing physicians throughout the United States.

AMCRA welcomes this opportunity to join the Committee in its review of the Medicare HMO/CMP option. AMCRA members are keenly interested in this option under which 32 AMCRA member organizations currently serve over 300,000 Medicare enrollees.

AMCRA and its members have a strong history of leadership in providing high quality HMO benefits for Medicare eligibles. AMCRA and 15 member HMOs sponsored a Medicare demonstration project in 1982. The demonstration project included seven (7) operational HMOs with 18,459 enrolled elderly when the project was deemed successful, terminated in 1985 and transferred to the Medicare TEFRA Program.

In other words, AMCRA and its members have been - and remain - pacesetters in providing quality HMO benefits to Medicare beneficiaries.

The Medicare HMO/CMP option was enacted by Congress as a partial response to the problems with the inappropriate incentives operating in the health system generally and with Medicare payment approaches in particular. Historic reliance on reasonable cost reimbursement in the hospital arena and reasonable charge reimbursement for physician services was extensively criticized for its inflationary nature and its tendency to promote overutilization of services. The HMO/CMP option was developed to allow Medicare to take advantage of alternative financing and practice arrangements that had evolved in the market and to stimulate their further development. HMOs and CMPs were welcome because of their managed-care approach to the individual patient, as well as their emphasis

on preventive health care and the provision of services in ambulatory instead of institutional care settings.

The financing of alternative health care delivery systems has prompted additional attention to quality of care issues. The changed incentive in HMO/CMP financing calls for attention to how the system responds to these incentives just as the incentives inherent in fee for service medicine merit review. AMCRA member plans are acutely aware of the importance of quality in the provision of services, if only to assure that they can attract and retain enrollees to stay in business. All of our plans have developed internal review procedures and enrollee appeal mechanisms to address quality of concerns. Thus, quality is indeed a matter which deserves constant attention by every individual and organization providing and purchasing health care, and quality should become increasingly important in the competitive, multiple-choice health care delivery system which AMCRA supports. Furthermore, quality and cost-effectiveness are intimately related. Preventing problems on an ambulatory basis, and offering specialized services only when required by the patient's condition all have obvious quality and cost implications.

In recognition of the importance of quality, AMCRA member organizations have taken many steps to assure that high quality care is provided to every patient. One typical member conducts surveys of patient satisfaction, gives patient complaints prompt attention and has consumer representatives over the age of 65 on its grievance committee, with authority to decide the appropriate response to patient complaints---a sort of patient peer review. As noted above, all have internal quality assurance procedures and enrollee appeal mechanisms.

AMCRA itself has devoted a great deal of attention to quality issues. Since 1979, AMCRA and the Group Health Association of America have co-sponsored the National Committee for Quality Assurance (NCQA). NCQA has taken the lead in developing standards for quality assurance programs and has provided a mechanism for peer review of individual quality assurance plans. AMCRA has sponsored educational programs on quality assurance, the most recent of which was aimed at identifying innovative quality assurance methods and approaches. Additional educational programs are planned. AMCRA has provided technical assistance to State health and licensure agencies in the development of external HMO review programs and standards. "Quality is Key" is AMCRA's motto for 1987.

In short, AMCRA believes that every patient deserves care of good quality. Unfortunately, under any payment approach---whether fee or cost based, or capitated---there are a limited number who will abuse the system. We share this Committee's belief that the bad actors on the health care scene, whether individual practitioners, health care institutions or alternative delivery systems should be rooted out. AMCRA will continue to lend its support to private and government efforts toward this end.

During 1986, the Congress also saw fit to enact a number of provisions dealing with the Medicare HMO/CMP option. The Consolidated Omnibus Budget Reconciliation Act provided for peer review of HMOs and CMPs and gave HCFA authority to review HMO/CMP marketing materials.

The Omnibus Budget Reconciliation Act of 1986 includes provisions requiring Medicare HMOs and CMPs to provide each enrollee with an explanation of his or her rights, including rights to benefits, restrictions on services provided by outside providers or suppliers, out-of-area coverage, coverage of emergencies and appeal rights; requiring access to financial records and disclosure of internal loans; authorizing civil money penalties for failure to provide medically necessary items and services; allowing Medicare beneficiaries to disenroll from an HMO or CMP at a local Social Security office; and requiring a report to the Congress on physician incentive arrangements by January 1, 1988.

The Health Care Quality Improvement Act of 1986 provides for a clearinghouse of information dealing with disciplinary actions taken against physicians, including those taken by an HMO or CMP, requires HMOs and CMPs to report such actions to the clearinghouse, and permits HMOs and CMPs to request information from the clearinghouse on practitioners with whom the organization has a current or prospective affiliation.

Much of the above legislation awaits full implementation and will significantly increase the Federal oversight of HMOs and CMPs with a Medicare contract.

As the Committee examines the Medicare HMO/CMP option, AMCRA offers the following observations and recommendations:

1. Despite problems involving individual organizations under contract with the Federal government, the HMO/CMP option must be preserved and strengthened since it provides real alternatives for those Medicare beneficiaries who freely choose to receive their health care in this way.
2. Federal law should be amended to encourage more participation by organizations eligible for Medicare contracts under prepaid financial arrangements. It may even be appropriate to broaden the kinds of organizations that should be allowed to qualify for such participation. These changes would allow Medicare to catch up with what is rapidly unfolding in the non-Medicare world.
3. Federal law should be amended to allow a variety of peer review approaches in the HMO/CMP arena. Current law essentially limits the quality review approach to that of the peer review organizations (PROs). While Congress has allowed for the competitive bidding of Medicare HMO/CMP review activities between PROs and non-PRO entities called quality review organizations (QROs), the Administration's view is that the statute requires QROs to be structurally identical to PROs, that reviewing physicians must reside in the state where

the services being reviewed were provided (even when this approach may exacerbate the potential for conflict-of-interest), and that review activities must be almost exclusively medical records-based and PRO-like, rather than allowing for other quality assurance approaches. In AMCRA's view, a greater diversity in review approaches should be allowed.

4. In general, the Congress should assure that the Federal government acts like a dependable business partner, willing to pay its reasonable share and promptly discipline or cease doing business with organizations unable or unwilling to meet high standards of quality care and service.

5. AMCRA members are especially concerned about the AAPCC formula.

As you are aware, reimbursement is based upon the AAPCC calculation by the federal government. This varies from county to county, although contiguous counties do not often show dramatic differences in actual medical costs. For example, in South Florida the Medicare reimbursement for Dade County is $292 per member; the Medicare reimbursement for neighboring Broward County is $245 per member; and Medicare reimbursement for Broward's northern neighbor, Palm Beach County, is $210 per member.

AMCRA is concerned that within thirty-five miles (Dade County line to Palm Beach County line) there is a difference of $82 in the average cost of health care. This amounts to a 28 percent decrease in reimbursement for care from Dade County to Palm Beach County. Our studies have shown that the reimbursement in Palm Beach county would be lower than the actual cost of providing care.

Mr. Chairman, as you can see, AMCRA is committed to assuring high quality health care alternatives for Medicare beneficiaries. We look forward to continuing to work with the Congress and the Administration and welcome this opportunity to present our views.

Thank you.

PREPARED STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

The American Psychiatric Association, a medical specialty society representing more than 33,000 psychiatrists nationwide, is pleased to have this opportunity to submit testimony on "Medicare HMO's: Problems, Protections, Prospects." A continuing major problem of Medicare HMO's is access of Medicare beneficiaries to the appropriate range of mental health services. Our comments focus on Medicare's inherently discriminatory policies against those with mental illness, the provision of limited mental health services by HMO's and inadequate marketing activity guidelines.

Medicare, Mental Illness and the Elderly

The health problems of the growing elderly population are often more complex than those of other age groups. Many elderly people have more than one health problem and may need more than one type of health care provider. Estimates indicate that some 15 to 20 percent -- between 3 and 5 million -- of our nation's more than 25 million older persons have significant mental health problems, yet they are denied adequate treatment because of the discriminatory "caps" imposed on psychiatric treatment under Medicare. Under the current Medicare system, outpatient benefits are effectively restricted to $250 per year after coinsurance and deductibles, and this amount has not been increased since the Medicare program's inception in 1965. In H.R. 2470 the Ways and Means Committee has improved this benefit to $1,000. As you may know, twenty to thirty percent of older Americans who have been labeled "senile" actually have reversible, treatable conditions. In the recent markup of catastrophic health insurance in the House Energy and Commerce Health Subcommittee the mental health benefit was changed to exclude "medical management" from any caps and allow 25 psychotherapy visits. If adequate mental health coverage was provided, these beneficiaries could become productive, active members of society, and avoid unnecessary and costly hospitalization. Coverage of the mental health needs of these elderly people under Medicare could provide the mentally ill elderly the dignity, productivity, and independent living which are the keystones of the Older Americans Act of 1965. In fact, Chairman Roybal's recent floor amendment to the Older Americans Act Reauthorization helps to further emphasize the mental health needs of elder Americans. Clearly there are instances where the compelling limitation on outpatient psychiatric care forces the use of more expensive inpatient care, and adds avoidable expenditures to an already strapped Medicare program. In fact, the

literature has documented an offset effect, namely a reduction in health care utilization when mental health services are provided.

Despite their many mental health needs, the elderly population receives only 6 percent of community mental health services and 2 percent of private psychiatric services. Medicare mental health coverage policy has discouraged our Medicare patients from seeking psychiatric care. Most researchers agree that the mental health needs of the Medicare population are underserved, and disagree only on the extent of underservice. The recent Harvard Medicare report recommends that coverage of mental health services be expanded. As the report noted, the omission of adequate coverage -- for example mental health care -- places older Americans at risk for significant expenditures.

Finally, studies have also indicated that in the population as a whole only between one-third and one-fifth of individuals identified as having a mental disorder during a six-month period used any mental health service from either mental health specialists or general medical physicians. The lack of utilization of mental health services is due to both poor coverage policy and the stigma associated with mental disorders. Therefore, the APA supports improved coverage of mental health services by Medicare so that Medicare beneficiaries can receive necessary treatment in appropriate settings.

HMOs

Given the inherently discriminatory coverage in Medicare, it is somewhat surprising that HMOs and CMPs offer to Medicare enrollees anything above the statutory benefit. According to recent data compiled by HCFA's Office of Prepaid Health Care, of the 135 HMOs/CMPs (with risk contracts) with slightly over 900,000 Medicare enrollees, 61 or 45% offer mental health benefits over and above Medicare covered services in either a basic or high option package. Unfortunately, the data does not delineate the additional services offered. While we have developed extensive HMO mental health benefit data, it is not specific to the Medicare program. APA has requested information from HCFA on the type of mental health benefits offered to Medicare enrollees in these HMOs/CMPs. We suspect that some offer the same coverage for mental illness as for physical illness. Our view is supported by our experience with other federal programs, including, for example, the Federal Employees Health Benefits Program (FEHBP) and the participation by federally qualified HMOs.

We are aware of the variability of existing coverage of all HMO plans that participate in FEHBP, HMOs that are representative of federally qualified HMOs. Of the 155 HMOs participating in FEHBP in 1985, 83 offered the FEHBP

evolved "standard" HMO mental illness coverage of 20 outpatient visits per year and 30 inpatient days. Twelve offered less than 20 outpatient visits or less than 30 inpatient days. Another 44 offered more than 30 inpatient days but only 20 outpatient visits, and only 17 offered an increased (over the 20/30 "standard") outpatient/inpatient benefit.

A major deficiency with the federally qualified HMO program has been the failure of the Department of Health and Human Services (HHS) to require non-discriminatory inpatient psychiatric hospitalization coverage as part of the basic health services benefit notwithstanding, in our view, a clear legislative mandate to do so.

On October 31, 1980, then HHS Secretary Harris approved final regulations which eliminated inpatient psychiatric care from the basic health services requirement for HMOs. Secretary Harris disregarded the general provision in Section 1302(1)(B) of the Public Health Service Act which states, "The term 'basic health services' means inpatient and outpatient hospital services." She relied upon the provision defining the term "supplemental health service" under paragraph (1) (D). However, paragraph (1) (D) refers to "short-term (not to exceed twenty visits) outpatient evaluation and crisis intervention mental health services," and not to inpatient hospital services, which are required under paragraph (1) (B).

HCFA, which now administers the federal HMO program, should initiate a review of the statute. We believe a correct interpretation will support our position, and provide appropriate inpatient psychiatric services to all HMO enrollees.

Finally, we raise the question whether the limited mental health services provided in these managed care systems are even readily accessible to patients. It appears that in some cases, individuals in need of treatment for a mental disorder are channeled without regard to the medical necessity or appropriateness -- for example the individual patient has concomitant or complicating medical conditions that might cause or exacerbate the demonstrated mental disorder symptoms -- to non-physicians rather than to psychiatrists, the medical specialist of choice. Thus, we recommend that HCFA monitor the delivery of mental health services so that access to needed care and the appropriate provider is assured.

Marketing Activities

HMO/CMP regulation pertaining to marketing activities is an important foundation for policing the enrollment activities of these managed care systems. The addition of the new subsections requiring the submission of all marketing materials to HCFA 45 days before planned distribution including the

specific authority to disapprove such materials if they are found to be inaccurate, misleading or misrepresentative of the organization, its marketing representatives or HCFA, is a commendable attempt to closely scrutinize marketing activities on behalf of the patient/subscriber. However, we believe this section should more adequately protect potential HMO/CMP enrollees and provide a mechanism for redress for those interested parties who wish to submit complaints regarding inappropriate marketing activities.

The APA is particularly concerned that HMO advertising of plan benefits may in some instances neglect to inform the public and the prospective Medicare beneficiary of the limitations on coverage of mental disorders. For example, an advertisement that sends the message that the HMO provides full or unlimited benefits may wrongly induce enrollment where in actuality a limited benefit for coverage of mental illness exists. Such advertisements may also unfairly induce enrollment where the public thinks it has unlimited access to care but access to services are severely limited through a variety of gatekeeper mechanisms. The inability to see one's personal physician, or unexpectedly have care provided by non-physician practitioners may not be apparent in advertisements but it may be the policy of a particular HMO. Because of our concern for the public, and in order to provide adequate guidance, the APA has recommended that HCFA develop within it marketing activities regulations the following guidelines:

1. Define the terms used in the statute, "Materially inaccurate, misleading and material misrepresentation," and how such would apply to HCFA authority and review of marketing materials.

2. Include in the scope of prohibited methods the use of deceptive words, phrases or illustrations. Identify by examples a list of these prohibited methods, where such words or phrases like "all," "full," "complete, "comprehensive," "unlimited," "up to," "as high as," are used in a manner which exaggerates any benefits beyond the terms of the actual benefit plan.

3. Prohibit the use of photographs, video presentations of illnesses or fictionalized accounts of illness that exaggerate the exceptional, catastrophic risks or out-of-pocket expenses that would induce enrollment out of emotional reasons.

4. Require that marketing materials disclose in writing with any plan offering or advertisement its exceptions, exclusions, reductions and limitations of coverage, including any limitation for pre-existing

conditions or any policy provisions relating to renewability, cancellability, revision or termination of any item or services covered.

5. Insure that testimonials used in advertising are accurate and documented.

6. Use statistics in only a fair manner reflecting accurately all of the relevant facts.

7. Prohibit disparaging comparisons or statements.

8. Use the name of the actual plan offerer.

9. Prohibit marketing methods utilizing introductory, initial or special offers unless in fact such statements are true.

10. Require that HMOs and CMPs maintain records and copies of all marketing materials available for inspection by HCFA.

11. State in writing any restrictions on access to specialist care and the use of non-physicians in providing medical care services.

While this list is not all inclusive, we suggest it embodies a number of important safeguards on the type of variety of promotional materials.

In addition, APA has recommended that HCFA establish and publicize a mechanism for filing complaints against HMO/CMP marketing activities. This complaint process should be available to all interested parties including, of course, HMO enrollees. For example, physicians or other health care providers, health related associations, patient advocacy groups, and other health plans should have the opportunity to report misleading advertising to HCFA. One approach to publicize this would be to require that all marketing materials include a statement regarding the submission of complaints to HCFA and provide an address or telephone number. Finally, HCFA must establish an administrative process for review of those complaints and be able to respond to them as well as take appropriate action against a plan that has violated the marketing regulations.

The APA believes the development and implementation of such marketing regulations is necessary to assure fair competition and to protect the public and the Medicare beneficiary from choosing a health plan that in reality does not serve their medical needs.

APA has also received complaints from members with documentation of specific problems patients have had in obtaining access to services in HMO's; (specifically, patients who need longer-term care are often denied access to appropriate one).

APA would be pleased to work with your committee to improve guidelines for HMO advertising and to improve access to mental health services in HMO's. As managed care becomes more prevalent we must develop appropriate methods for delivery of services for all patients.

PREPARED STATEMENT OF THE MEDICAL GROUP MANAGEMENT ASSOCIATION, DENVER, COLORADO

MEDICARE HMOs

The Medical Group Management Association (MGMA) appreciates this opportunity to submit its views on the role of health maintenance organizations (HMOs) and competitive medical plans (CMPs) in the Medicare Program. MGMA is the oldest and largest professional association of its kind, representing over 3,300 medical groups in which over 70,000 physicians practice their profession.

MGMA member groups represent a broad spectrum of health care service providers, including large multispecialty clinics that draw patients in need of sophisticated tertiary care from throughout the world, to small single specialty group practices serving a single community. Some groups operate solely on a fee-for-service basis, others are completely prepaid, and some combine elements of both fee-for-service and prepaid practices. Many are free-standing physician practices, but a growing number are affiliated with hospitals, medical schools, or HMOs, and in some cases, they combine all three.

MGMA member groups have considerable experience with prepaid health care in the Medicare program. Several were among the first health care prepayment plans to contract with Medicare on a cost basis, while others were among the first to demonstrate the viability of a capitated, risk-based approach. A significant number have now qualified as HMOs or CMPs under the TEFRA risk contract provision, while many others provide services under contract to HMOs that in turn contract with HCFA.

More MGMA group practices would like the opportunity to participate in the TEFRA program but are ineligible because they do not meet the requirements for being either a Federally qualified HMO under Title XIII of the Public Health Service Act, or a CMP as determined by the Public Health Service.

Other MGMA member groups may already offer an HMO option as part of their practice, but are often excluded from the program because of the "50/50" rule which does not allow a Medicare HMO to have a total patient population made up of more than 50 percent Medicare beneficiaries.

Still other groups cannot afford to take the financial risk of being paid at only 95 percent of the average adjusted per capita cost (AAPCC), which is the rate set forth by HCFA in the contract provisions.

MGMA supports the continued availability of both cost-and risk-contracting opportunities which, along with fee-for-service practice, insure both patients and physicians flexibility and choice. While the highly publicized contract problems involving the now terminated IHC contract in Florida provide appropriate cause for heightened Congressional oversight and tightened HCFA management of the program, they should not deter the federal government from further developing the capitation option.

The experience of the TEFRA program to date, plus the problems associated with IHC, do suggest certain refinements to the existing rules and regulations which might enhance the success of the program in its next stage of development.

QUALIFYING ORGANIZATIONS

The future of the Medicare risk contract program depends upon the medical groups' and the beneficiaries' willingness to participate in the program. Many medical groups that are not Federally-qualified HMOs or CMPs have only limited, if any, experience with prepaid or capitated payment systems. A program such as this one, if expanded, would provide a good opportunity for those medical groups to gain some experience in prepaid care and then, based on that experience, they could decide whether or not to pursue efforts to become Federally qualified. Without such opportunities, there is little doubt that the Medicare risk contract program could never expand beyond the number of groups already qualified to participate.

The TEFRA risk contract program has attracted a "mixed bag" of contracting parties including well established commercial health maintenance organizations using either the group or staff model, and a growing number of independent practice association (IPA) arrangements. Many of these organizations have established track records with Medicare now, as well as with the commercial markets, and have proven their abilities as true health

care delivery systems. In some instances, however, the TEFRA program has attracted what are essentially "pass-through" entities--organizations that specialize in marketing and enrollment, but then contract out all of the health care services. In some cases, these organizations are serving the insurance or "risk taking" function, but in others even this is passed on to hospitals and medical groups. MGMA is aware of some situations in which the contracting organization bears essentially no risk, and simply takes a significant percentage of the Medicare and commercial premium dollars "off the top" to perform marketing and administrative functions. With appropriate oversight, these arrangements can work very efficiently. However, it is critical that both the government and the beneficiary understand that under such arrangements, they are not dealing with organizations whose whose first mission is the provision of health care services.

At the same time, we think the government should look for opportunities to contract directly with organizations whose true mission is in health care delivery, and who are now the true "risk takers" under some pass-through arrangements. Permitting well-established medical groups to contract directly with Medicare would be beneficial for several reasons. First, it permits the beneficiary to change his payment arrangement without disrupting the patient/physician relationship over time. Multispecialty group practices emphasize continuity of case and comprehensive care management under one roof, whereas in some of the pass-through arrangements neither the enrolling entity nor the contracting providers have permanent patient relationships.

Second, most large multispecialty group practices already have sophisticated quality assurance programs in place within the internal structure of the practice. These should facilitate the government's job of quality assurance in the prepaid setting, and provide an additional level of assurance to the patient.

Third, established medical groups have a long history of providing health care to large numbers of individuals within their communities, including large numbers of Medicare patients. They have proven their financial and market viability gradually through patient satisfaction and the provision of high quality care. They have management and administrative structures in place to handle the extra challenges associated with prepaid contracting.

THE "50/50" RULE

The 50/50 rule was written into the TEFRA risk contract program in order to assure that the participating HMOs and CMPs had a good mix of Medicare and non-Medicare patients. According to the rule, no more than 50 percent of patients enrolled in the prepaid plan could be Medicare beneficiaries. Unfortunately, this rule prohibits many groups from being eligible for CMP status and therefore ineligible to enter into a TEFRA risk contract.

IMC has focused much attention on the 50/50 requirement in Medicare, and unlike many other observers, MGMA submits that this attention is largely misplaced. The 50/50 rule was never intended to be more than a proxy for either financial viability of acceptable quality as measured by the commercial market; it is an imperfect proxy at best. While IMC never met the percentage requirement, it had a significant number of non-Medicare enrollees, probably more so than many smaller contractors who were in compliance with the 50/50 requirement. Had it been willing to slow the growth of Medicare enrollment, IMC could have complied with the rule without otherwise changing its mode of operation, and there is no reason to believe the outcome would have been any different.

The current application of the rule produces some anomalous results. For example, a pass-through model HMO which has successfully enrolled 10,000 commercial patients, then contracted with a group practice for all their health care, would be eligible to enroll up to 10,000 Medicare patients, including those currently served by the group practice on a fee-for-service basis. The medical group on the other hand, which serves the 10,000 commercial patients, may take the full risk with respect to their care, and already has a well established Medicare population on a fee-for-service basis would not be qualified to contract if their total patient population is more than 50 percent Medicare. Ironically, the HMO marketing organization may have the ability to enroll both commercial and Medicare patients only because it can guarantee to prospective enrollees that their medical care will be fully provided by the established group practice.

In other situations, one or more HMOs have largely cornered the group employer market with commercial patients, and yet are not interested in offering a Medicare plan. Other medical groups in such an area would be prohibited from offering a prepaid option to Medicare beneficiaries unless

they are willing at the same time to attempt to penetrate the commercial market which essentially would have been already carved up by the large HMOs.

MGMA has encouraged HCFA and would urge the Congress to rethink both the purpose and application of the 50/50 requirement, and to focus more on the mix achieved by the entity ultimately providing the care and taking the risk, as well as on the factors--financial viability and quality--for which the rule was intended.

AAPCC

Paying groups 95 percent of the AAPCC is certainly not the best method of determining rates paid to HMOs. For some groups, the rate is equitable, the group makes a profit, and the Medicare patient benefits since the law requires the groups to turn some of the profit into improvements or additional benefits to the enrollees. For others, being paid only 95 percent of the AAPCC would put them at a financial loss and therefore, they are not interested in participating.

In many cases the AAPCC does not accurately reflect what the actual charges and costs are for a given geographic area. In some areas the AAPCC is so low that medical groups would not be interested in capitation arrangements because their losses would be too great.

The concern of most groups is that HCFA and/or Congress will lower the percentage of the AAPCC paid to Medicare HMOs in order to achieve short-term budget savings at some point in the future. Such a move would unfairly penalize groups that entered into a risk contract in good faith that the rate of payment would be adequate to cover the costs of the program.

Congress should require HCFA to establish the AAPCC through rulemaking, and to rationalize the calculations so that large variations from one side of an artificial geographic boundary to another are evened out. Congress should further consider authorizing HCFA to make multi-year contracts with appropriate updates to the rate from year to year so that contractors have stability and predictability with respect to the rate. Above all, Congress should exempt the AAPCC from arbitrary short-term budget cuts, which even if symbolic in amount, do much to destroy confidence in the rate. From a group practice perspective, one of the great advantages of capitation is stability and predictability of cash flow. If that element of the program is undercut, fewer groups will wish to participate.

CONCLUSION

In summary, MGMA urges continuation of a viable prepaid contract program in which medical groups have an opportunity to contract directly with HCFA for the provision of capitated care to Medicare beneficiaries. The existing TEFRA program is a good first step, and can be built upon to enhance opportunities for both patients and providers while at the same time procure for Medicare the budget restraint inherent in a more competitive medical marketplace. The Medical Group Management Association would be pleased to work with members of the committee and staff to elaborate further on the above suggestions.